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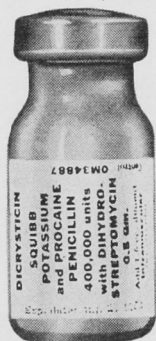
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Medicine

Coarctation of the Aorta With Report of Two Cases

M. G. Israels, M.D.

Coarctation of the Aorta is not common but on the other hand is by no means rare. The incidence of case-finding has increased considerably, since the advent of surgical procedures to correct this condition. Maude Abbott, reviewing the recorded two hundred cases from 1791 to 1928 found that only 14% were correctly diagnosed before autopsy. Reifensstein, Levine and Gross recording 104 cases from 1928 to 1947 showed an increase in clinical recognition of approximately 40% ante-mortem.

The incidence shows the lesion occurring in 1 in 3,000 to 1 in 4,000 autopsies. The ratio of males to females is approximately four or five to one. The ages range from six months to ninety-two years. Christensen and Hines in their report show only 26% of cases diagnosed below the twentieth year, the maximum age deemed advisable for surgery.

The average age at death is approximately 35 years, 61% dying before or during the fortieth year.

Clinical Features

The majority of cases are asymptomatic, and are accidentally found by the radiologist or by the internist, the cases being referred for investigation of a valvular murmur or hypertension.

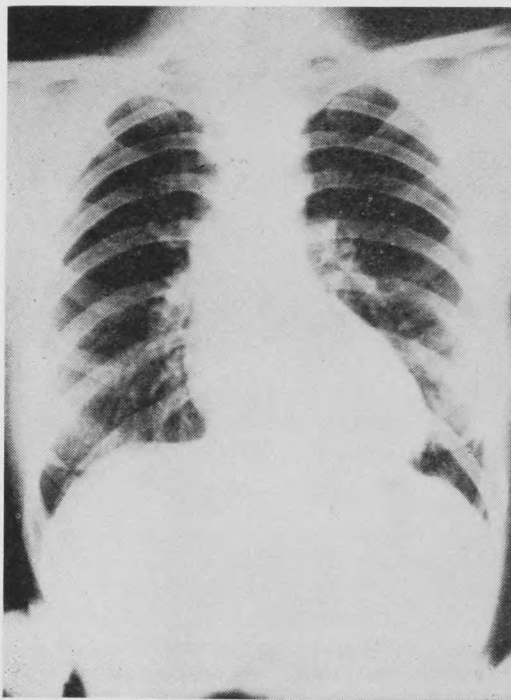
The clinical examination discloses a systolic murmur over the precordium more pronounced at the base of the heart, and particularly posteriorly between the scapulae, where it is usually of greater intensity than anteriorly. The murmur is transmitted upward into the neck.

The presence of a diastolic component is usually indicative of an associated abnormality such as patent ductus arteriosus or bicuspid aortic valve.

The blood pressure is elevated in the upper extremities to hypertensive levels, and arterial pulsation in the femorals is diminished or usually absent in about 84% of cases.

The evidence of visible pulsations in vessels about the scapulae or interscapular space indicate well developed collateral circulation. The radiological evidence of this is demonstrated by "notching" or "crenation" of the lower rib borders. This finding is not present in all cases but is good indication of the degree of coarctation, being most marked in severe cases.

Pathologically there is a definite relationship between the degree of coarctation and the extent of development of collateral circulation. Reifensstein et al, demonstrated that the cases showing most marked development of collateral circulation showed the greatest degree of coarctation. If the collaterals developed are other than the inter-costals, rib changes may not occur even in marked cases. When, however, visible erosion of the ribs does occur marked coarctation can always be postulated.



Case I—Film March 15, 1946, shows a normal cardiac shadow with absence of the aortic knob and no gross evidence of rib crenation.

Other radiological findings are evidence of left ventricular hypertrophy and absence of the aortic knuckle.

The following cases are presented to emphasize the necessity of considering this lesion as a cause of hypertension associated with pregnancy.

Case I

Mrs. K. M. K., age 22 years, was referred on March 5, 1946, by a gynecologist in her fifth month of pregnancy for the investigation of hypertension. The initial reaction was that it was an early

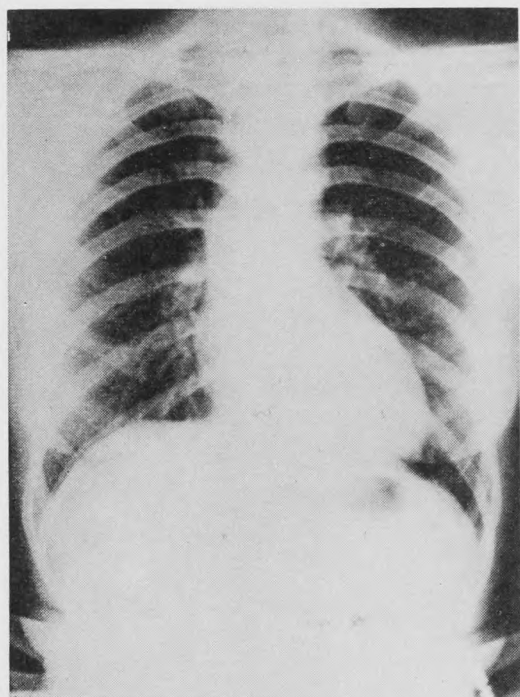
toxemia. The patient had no complaints. The blood pressure was 178/90 in the right arm and 170/90 in the left. There was a grade two systolic murmur audible over the precordium, slightly louder at the base of the heart. It radiated upward into the neck. It could easily be made out between the scapulae, where it was of greater intensity.

The pulsations were far less than normal in the vaginal fornices and none could be felt in the femorals. The pressure in the legs was 80/60.

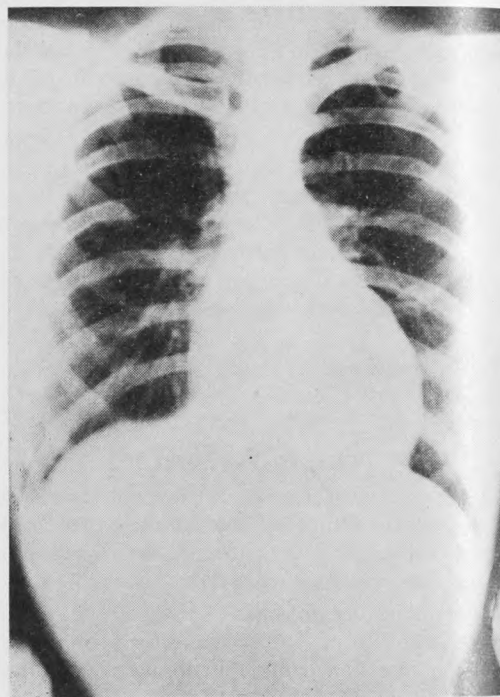
Roentgenograms of the chest showed no cardiac enlargement, an absent "aortic knuckle" with no evidence of rib-notching. The descending aorta could not be seen. Planograms failed to visualize the coarcted area. A diagnosis of coarctation of

account of a heart murmur and associated hypertension. She had no clinical symptoms. Her blood pressure was 200/120 in the right arm and 180/110 in the left. There were "blowing" grade two systolic murmurs audible over the mitral and aortic valvular areas. The murmur was quite audible to the left of the vertebral border between the scapulae. Pulsations were absent in both femoral arteries with blood pressure 60/40 in these vessels.

The teleroentgenogram showed left ventricular hypertrophy of a concentric type, with blunted apex, absence of the aortic knob, and "crenation" of the lower borders of the fifth, sixth and seventh ribs.



Case I, Film No. 2—May 29, 1951. Film shows no change in the cardiac silhouette. Absence of the aortic knob with still no evidence of collateral circulation affecting rib margins.



Case II—November 23, 1950. Film shows marked left ventricular hypertrophy of the concentric type. Absence of a prominent aortic knuckle in the presence of marked hypertension. Crenation of the lower margin of the 5th, 6th and 7th ribs on the right and of the 6th on the left.

the aorta of the adult type, with no visible development of the collateral circulation was made.

Her baby was delivered naturally on April 12, 1946.

Subsequent films over the past five years have shown no increase in size of the cardiac silhouette, and no development of collateral circulation. She was delivered of a second child on May 5, 1948, without difficulty.

Case II

Mrs. N. A. H., age 23 years, was referred for investigation in the fourth month of pregnancy on

A diagnosis of "coarctation" of the aorta was made of a more "severe" type.

Discussion

Although coarctation is reported as more frequent in males at an incidence of 4 or 5 to one, the above cases reported in two females indicates the necessity of ruling out this lesion, as a cause of hypertension associated with pregnancy. The routine palpation of the femorals as part of the clinical examination, together with good auscultation of the back of the chest in the presence of valvular murmurs, are simple procedures indeed.

to carry out. With the advent of arteriography the intensity of the lesion will be more meticulously defined.

The problem of surgical interference in the first case was brought up after the patient read an article in a lay magazine which indicated that her life expectancy was 40 years. The ideal age for surgery is between ten and twenty years, before much dilatation and thinning of the aortic arch has occurred. This patient has been under observation for five years, has shown no gross cardiac enlargement or signs of failure and barring any fortuitous events such as the occurrence of subacute bacterial endocarditis or a congenital cerebral aneurysm, was told that some cases have reached the three score and ten without difficulty. Future pregnancies have been "banned."

The height of the blood pressure in the upper extremities alone is not indicative of the extent of coarctation, rather the difference in the pressure between arm and leg has a greater clinical significance. The wider the difference the more marked the constriction.

Surgical interference has been advised in the

second case following her delivery. The signs of left ventricular hypertrophy, the wide variation in pressure between upper and lower extremities and the well developed collateral circulation are the criteria, for this decision in her case.

Summary

Two cases of coarctation of the aorta in women are presented, to indicate the necessity of considering this lesion, as a cause of hypertension in pregnancy.

The consideration for surgical interference on a clinical basis is briefly discussed.

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Physiology of the Biliary Tract*

J. A. Hildes, M.D., M.R.C.P. (Lond.), F.R.C.P. (C)

Department of Physiology and Medical Research, The University of Manitoba and the Department of Medicine, Winnipeg General Hospital

The biliary tract is embryologically an off-shoot from the gastro-intestinal tract. The main bile ducts and gall bladder possess, in a general way, the same functions as the gut; that is, absorption, secretion and motor activity. However these functions of the biliary tract are very specialized; absorption is, for the most part, concerned with concentrating the bile; secretion is relatively unimportant and is limited to a small amount of mucus; and the motor functions are modified to assist in the concentration of bile and its intermittent release into the duodenum. The purpose of this paper is to review these functions and particularly to relate them, if possible, to the genesis of biliary disease.

Concentrating Function of the Gall Bladder (11, 6)

The presence of the gall bladder in the duct system which conveys bile from the liver to the intestine allows this important digestive juice to enter the gut in a concentrated form when it is required for digestion. The gall bladder concentrates the bile 5 to 10 times by the absorption of water, chloride, bicarbonate and sodium ions. Water is absorbed at a rate of about 5 cc. per minute. Thus the gall bladder, in spite of its small capacity,

may store 12 hours of liver secretion. Calcium is also absorbed by the gall bladder mucosa but at a slower rate than water so that some increase in concentration occurs. Pigments, bile salts and cholesterol are not significantly absorbed by the normal gall bladder. Therefore, these substances are many times more concentrated in gall bladder bile than in liver bile. The absorbing power of the gall bladder is not greatly influenced by drugs or nervous stimuli.

The etiology of gall stones is still controversial but must be related to the question, "What keeps the cholesterol in solution?" During concentration the reaction of the bile becomes more acid. Alkalinization of the bile may precipitate the cholesterol. Probably even more important is the bile salt to cholesterol ratio. Newman¹¹ found this ratio to be about 18 to 1 in normal human gall bladder bile but in subjects with gall stones the ratio fell to about 2.5 to 1. This could be due to failure of the liver to secrete bile salts but is more likely due to the diffusability of bile salts through the mucosa when the gall bladder is acutely inflamed.

Still another explanation is that the abnormal gall bladder secretes cholesterol. The only evidence for this is presumptive and rests on the histological appearance of lipoid in the gall bladder mucosa in the condition commonly called "strawberry gall bladder." Multiple faceted stones are apparently laid down quite quickly¹. These stones are all of the same age or there may be two or three broods. At any rate gall stones

*Based on a contribution to the round table conference on gall bladder disease, University of Manitoba Refresher Course, 29 March, 1951.

are apparently not formed continuously. This suggests that the change in function that leads to the laying down of stones is transient and reversible. Of course normal function is jeopardized by the presence of stones, which may ulcerate the wall or obstruct the neck of the gall bladder and so cause further attacks of acute inflammation which may lead to further families of stones.

It is obviously advantageous to conserve digestive juices until they are required for digestion.⁶ However, the concentrating function of the gall bladder is not essential to life or even to good health. Several species of animals have no gall bladders and there is no apparent reason why some have and some have not.¹¹ There is some evidence that the livers of animals normally without a gall bladder secrete a more concentrated bile.¹¹ Also in animals and humans whose gall bladders have been removed the bile ducts dilate in an apparent effort to take over the function of the gall bladder, and allow bile to enter the duodenum intermittently. In this circumstance the dilated ducts may concentrate the bile to some extent.

Motor Activity of the Biliary System

The gall bladder fills and empties via the cystic duct. This is effected by co-ordinated muscular action of the gall bladder wall and the sphincter of Oddi. This concept was put on a firm basis by the work of McMaster and Elman¹⁰ and has been amply confirmed. The secretory pressure of the liver is about 30 cm. of bile. The force of gall bladder contraction has about the same value. The resistance to the outflow of bile from the common bile duct into the duodenum (due mainly to the muscular sphincter at the lower end of the bile duct) is about 80 cm. of bile when the sphincter is contracted. It is obvious then that the gall bladder may contract but cannot empty unless the sphincter of Oddi is relaxed. It has also been shown that normal gall bladder filling only occurs when the sphincter of Oddi is contracted. Then the secretory pressure of the liver forces bile along the cystic duct.¹³

The biliary tract is supplied with motor nerves via the splanchnic nerves and the vagus nerves.⁶ Experiments involving cutting and stimulating these nerves in animals have given rise to much confusion about the normal and abnormal function of the nerves. Even the demonstration by Ivy and his associates⁶, confirmed by others, that the gall bladder fills and empties quite well without nerves does not mean that these nerves do not play a part in normal function. However, the hormone mechanism involving cholecystokinin appears to be more important.

During fasting the sphincter of Oddi is closed and the gall bladder relaxed. The intake of food, particularly fat, causes the gall bladder to contract

and the sphincter to relax. In animals, and possibly in humans, psychic stimulation of this mechanism occurs. This is one explanation of the occasional finding of a "non-functioning" gall bladder by x-ray in a normal subject.

The question of whether this reciprocal motor activity (either nervously or hormonally controlled) is ever deranged enough to cause biliary tract symptoms without organic biliary disease, is an open question.

Sensation From the Biliary Tree

As with other hollow viscera the stimulus that gives rise to visceral sensation is an increase in pressure caused by spasm or distention. The impulse pathway is via afferent fibres travelling with the sympathetic nerves back to the spinal cord. This has been demonstrated in humans by Bingham, Inglefinger and Smithwick.³ Two patients with common duct T-tubes were subjected to sympathectomy for hypertension, one side at a time. The T-tube was perfused with water at a pressure sufficient to produce pain. Unilateral sympathectomy raised the pain threshold and shifted the site of the pain (formerly mid-line) to the unoperated side. Bilateral sympathectomy abolished pain.

Ivy and his collaborators distended balloons in the gall bladder and the common bile duct of dogs. Distention of either balloon produced a pain reaction with nausea, vomiting, salivation and irregularities of respiration. Sympathectomy abolished the pain but the nausea and the vomiting remained. Vagotomy abolished the nausea and vomiting. Sympathectomy and vagotomy abolished all the reactions.⁶ These reactions were elicited with less pressure in the bile duct than in the gall bladder. Reflex excitation of the antrum of the stomach appeared to play some part in producing the symptoms. Resection of the pylorus and antrum lessened the nausea and vomiting but did not altogether abolish them.

Can sufficient pressure be produced by sphincter spasm to cause pain in a normal subject? Ivy⁷ has reported that, in 19 normal subjects, intravenous injection of cholecystokinin and secretin stopped the flow of bile into the intestine; and in 3 subjects typical gall bladder distress was elicited. This was promptly relieved by instilling a $Mg SO_4$ solution into the duodenum. Westphal¹² is also said to have produced biliary pain by injection of large doses of pilocarpine. This was relieved by atropine.

The Effects of Cholecystectomy on the Bile Ducts

In dogs cholecystectomy is immediately followed by relaxation of the sphincter of Oddi and bile trickles continuously into the duodenum. However, the sphincter regains sufficient tone so that invariably there is marked dilatation of the bile ducts in two months. If the sphincter is re-

removed or divided at the time of the cholecystectomy the ducts do not dilate.⁸

In a post-mortem study² the common bile duct was found to be dilated in 86% of subjects who had had symptoms following cholecystectomy, but only in 17% of subjects who had no symptoms following cholecystectomy. This suggests that in some humans removal of the gall bladder is followed by sufficient contraction of the sphincter of Oddi to cause marked dilatation of the ducts which, in turn, is associated with pain. It has been claimed that these symptoms can be relieved by antispasmodic drugs¹¹ and by surgical excision or exclusion of the sphincter.⁵

Perhaps the dilatation of the ducts is more likely to occur when a relatively normal gall bladder is removed than in a patient who has had repeated attacks of colic and inflammation leaving a functionless gall bladder fibrosed about the stones. It is well known clinically that the best results of cholecystectomy occur in patients who had had long standing disease. However, the reasons behind this clinical finding are still matters of controversy.

Summary and Conclusions

The mechanism concerned in the concentrating and motor functions of the gall bladder have been reviewed as well as the sensory nerve supply to

the biliary tract.

Although the etiology of cholelithiasis is obscure there is clinically a close association between biliary tract disease and the presence of gall stones. In fact the existence of symptoms arising from the biliary tree in the absence of stones is doubted by many clinicians. However the experiments and observations noted above indicate that this possibility cannot be denied.

Acknowledgment

Dr. J. W. Macleod suggested the presentation on which this paper is based and read the manuscript. His help is gratefully acknowledged.

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Drug Eruption Treated with Cortisone A Case Report

Saul S. Berger, B.A., M.D.

This report deals with the case of a 38-year-old white woman, married, with two children age 13 and 9. Family history revealed that her father had asthma and her 13-year-old child had eczema since birth. This patient had an eruption involving the skin of the dorsa of the hands and of the popliteal and cubital fossae for past 13 years, commencing with the heat of the summer and lasting for approximately a month. She described her eruption as red, itching, with water blister formation, then thickening and cracking of the skin. In November, 1950, her eruption recurred for the first time in the fall of the year—affecting the dorsa of the hands and persisting despite treatment.

She was first seen by me on March 6, 1951. The patient was in obvious distress. Her skin over entire body was a beet red, tender and hot to the touch. Her face was red and puffy—most marked about the eyes. The arms and forearms were swollen as were the lower extremities. One could elicit pitting edema over the lower legs. The hands were swollen, the skin thickened and red and well excoriated.

The patient had accumulated a host of remedies since the recurrence of her eczema in November. She had used many medications — ointments, lotions, pills, etc. She flitted from physician to physician and went outside the medical profession for aid. She admitted that a few days before calling me she went to see an elderly woman who told her that it was necessary to prove whether her eruption was eczema or not. Her would-be benefactor collected soot from the bottom of a cook stove plate, added butter and garlic and perhaps other ingredients and cooked this into a concoction. The patient was warned that if her eruption was indeed eczema, the patient would start swelling which was exactly what happened. Topical applications in her treatment included Histadyl and Surfacaine cream, Furacin ointment, Surfacaine Lotion, Caladryl Lotion; a Germicidal Soap and Burrow's Solution Soaks. Patient was advised to use the Burrow's Solution 2 teaspoons to a pint, which is a 1:60 solution and very mild. Instead patient used it full strength and of course irritated her skin. Oral Medications taken were Amytal, Phenobarbital, Phenobarbital with Ephedrine, Phenergan, Benadryl, Dexedrine and Methadrine.

Patient was advised to discontinue using all previous medications except Benadryl. She was

told how to prepare and use a Colloidal bath and she was given a zinc oxide olive oil mixture as a soothing lubricating preparation.

A few days later her condition was not improved. Patient was experiencing chills and there was suggestion of the beginning of an exfoliative process of the skin. Patient was admitted to hospital on Sunday, March 11th. Physical examination other than skin was negative; Blood Pressure was 150

90; Urinalysis—negative, and White blood count read as follows: White Blood Cells 15,000, Polymorphs 59%; Stabs 4%; Eosinophils 8%; lymphocytes 26%; monocytes 3%. It was felt this patient would do well on Cortisone therapy, reports in the literature having testified to the satisfactory use of Cortisone in lesions secondary to drug reactions.

On Monday, March 12th, patient was given Cortisone intramuscularly according to the following regime:

First day, March 12, 150 mg—twice daily.

Second day, 100 mg—twice daily.

Third, fourth, fifth, sixth and seventh day, 100 mg daily. Patient received in all 1000 mgs. of Cortisone in one week, last injection being given March 18th. Patient was placed on a salt-free diet—was weighed daily and blood pressure recorded daily. There were no remarkable fluctuations in the above readings while patient was on Cortisone therapy. In addition patient was given colloidal baths, 1:20 Burrow's Solution compresses, olive oil for the dry areas, and Chloral Hydrate 25% solution—1 to 2 teaspoons at night when necessary for sleeping.

The patient improved rapidly on this regime and at the end of a week was so much better, she demanded release from hospital. Her edema and redness had almost disappeared. One could no longer elicit pitting edema of the lower extremities. Patient was very comfortable and in good spirits. Since she insisted, she was discharged from hospital on Tuesday, March 20. She was told to go on a high salt diet for two weeks from date of discharge.

Since it had not been established what the causal agent was in her dermatitis, she was emphatically warned not to use any medication topically or orally, that was used prior to admission in hospital. Wednesday, March 21 (patient was discharged Tuesday evening, March 20), patient took one small white tablet. Almost immediately after taking the tablet, the patient experienced sudden swelling of the face with extreme redness—especially peri orbitally. There was redness and swelling especially of the forearms—and to a lesser degree of all other previously affected areas. She was roughly about 25% as bad as when admitted to hospital.

The patient was now convinced that she would do well to follow instructions. She was placed on anti-histaminic therapy for two weeks plus a soothing lotion and at end of two weeks was in a much improved condition.

Comment

It was obvious that the present state of the patient was brought about by topical or oral medication. The topical medication could have acted either as an irritant or by reason of the patient being or becoming sensitive to it, or by both mechanisms together. The oral medications could have acted either as a toxic agent or by reason of the patient being or becoming sensitive to it. The small white tablet which the patient took soon after discharge from hospital and which caused a recurrence of her dermatitis was proven to be phenobarbital grs. $\frac{1}{2}$, and it seemed obvious that the patient was allergic to it. One could argue re the phenobarbital sensitivity, that the acute reaction could have been a relapse from post Cortisone therapy, and that the reaction might have happened if the patient did not take phenobarbital. But the reaction was too acute and explosive and happened immediately after the ingestion of the phenobarbital tablet. It would be interesting to know if the patient would have flared up from the phenobarbital medication while on Cortisone.

Dr. Henri Dubosis-Ferrière, associate professor at Geneva University, Switzerland, feels that Cortisone, which prevents the reaction due to stress is of greatest value in allergic diseases where the reaction of the organism are out of proportion to the stress factor.¹

He feels that in diseases in which the reaction to stress represents a defence permitting localization of the disease, one must consider whether Cortisone is more harmful than useful. He explains that in an aseptic wound—a vascular response occurs consisting of vasodilatation, hyperemia, edema and leukocytic diapedesis, allows the cicatrization of the wound. On the other hand, when a pathogenic agent penetrates—a similar reaction occurs in an attempt to limit the infection—and there is mobilization of the reticulo-endothelial system to fight the dissemination of bacteria. Cortisone he points out, is supposed to paralyze the natural defence mechanism and, therefore, if it is used the generalized spread of the infection may be encouraged.

From the above it was felt that Cortisone was justifiably used in the above illustrated case of an allergic drug reaction. It is in conditions such as these that Cortisone can be most useful. This report only points out that the patient had an unusually quick response to therapy. It was felt that Cortisone was the factor in the effective therapeutic response. Results of control series, if possible to set up, would help to establish evidence one way or another. However, similar cases have

persisted much longer even after offending agents have been eliminated.

Commonest skin eruptions due to barbiturates are morbilliform, scarlatiniform and urticarial, purpuric, and haemorrhagic dermatoses, and multi-form and bullous eruptions of mucous membranes.² Some of the effects of the drug are due to sensitization, especially those reactions characterized by pruritus and whealing, while those with morbilliform, scarlatiniform and maculopapular eruptions with associated fever, conjunctivitis, stomatitis, and pharyngeal lesions are thought to be toxic. The

two types do not usually occur in the same patient.³

In this case the eruption was considered to be due to sensitization. Whether Cortisone would help the toxic manifestations, this report does not attempt to answer.

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Orthopedics

The Use of Plastics in Modern Medicine and Surgery

Alexander Gibson, F.R.C.S. (Eng.)

"Man," Carlyle has said, "is a tool-using animal." During the half-million or so of years during which Homo Sapiens has been present on the earth, the material he has employed and the nature of the tools themselves has varied. So prominent has been this aspect of his development that we are accustomed to speak of him as Man of the Old Stone Age, Palaeolithic; of the New Stone Age, Neolithic; of the Bronze Age, and until recently of the Iron Age. The "Golden Age," it need hardly be said, is essentially mythological. It has never existed in the past; it is emphatically not of the present, and is not likely ever to come to fulfilment in the future. Indeed, in the opinion of many, the proximate future is likely to be known as the Age of Plastics. The achievements of the chemist have been so startling that the prophecy may well prove true.

What are plastics? According to Carleton Ellis, "the term plastic is applied to anything which possesses plasticity, that is anything which can be deformed under mechanical stress without losing its cohesion, and is able to keep the new form given to it." Most plastic products as we see them today are quite rigid. The majority belong to one of two types:

(a) Those which can be softened over and over again by heat and pressure; they are thermo-labile or thermo-plastic.

(b) Those which are transformed by heat and pressure into insoluble, infusible masses. They cannot be softened again no matter how much heat is applied. These are the thermo-stable or thermo-setting plastics. Most of the products of which the surgeon makes use belong to the thermo-labile group. Some of them are like glass, equalling or indeed surpassing it in transparency, while at the same time they are not so brittle and are much

lighter in weight. Steel is much stronger than plastic but is very much heavier. It is harder to model, is liable to corrosion, and is electrolytically active. Plastics are poor conductors of electricity, and are not influenced by the body tissues. For these and other reasons plastics have been used for a good many years for such things as artificial eyes, and the lenses of spectacles. For the latter purpose, lightness is of great value; if dropped on the floor the lenses do not break; the one disadvantage is that the surface is rather easily scratched.

The thoracic surgeon places little plastic balls, like ping-pong balls, in the cavity produced in the chest by thoracoplasty. Plastics are used by the urologist for catheters. Recently it has been claimed that a portion of the oesophagus removed for malignant stricture has been successfully replaced by a plastic tube. Dentists employ a thermo-labile plastic (methyl methacrylate) in the making of dentures. It is, perhaps, the orthopaedic surgeon who makes the most spectacular use of plastics. The bony framework of the body seems almost to throw out a challenge to his ingenuity. The replacement of skull defects is an obvious field; so far it has not been possible to make up for defects in the shaft of the long bones. Up to the present most attention has been focused on deformities involving the hip-joint, and especially on the head of the femur. There are a number of conditions which appear to be amenable to the use of plastics. Let us consider first the fairly frequent condition of Osteo-Arthritis. This may come as a sequel to a severe injury or develop after prolonged over-use. Until a few years ago, attention was directed to re-modelling the head of the femur in this affliction. The head was re-shaped and put back in the acetabulum without any interposing material. Some of these cases did well, but others suffered progressive attrition of the head which was no longer covered by a protective layer of compact bone or of articular cartilage. The next essay was to cover the head with a layer of fascia

obtained from the thigh. The results were disappointing. The joint tended to become stiff and painful. Baer of Baltimore introduced a membrane to cover the head of the bone. It was made of chromicised pig's bladder. It proved to be as unsatisfactory as fascia and has long been discarded. Smith-Peterson of Boston then directed his attention to the use of a cap for the vulnerable stump of the neck. Many substances were tried; the most suitable turned out to be Vitallium, a compound of cobalt, chromium and molybdenum. This has been extensively used during the last ten or twelve years. It is a mushroom-shaped covering for the denuded and remodelled femoral head. The use of this device marked a great advance. It has been established that under suitable conditions articular cartilage can actually be re-formed under the cup. Two disadvantages have marred the success of this procedure. The cup itself tends to sink into the bone at the bottom of the acetabulum, and the neck of the femur tends to shorten so that the rim of the cup may come to rest on the bone about the base of the neck. The net result is that as time goes on, movement at the hip-joint tends to lessen in range. Instead of vitallium, Lucite, a plastic material has been tried; this material was discarded because it tended to break under stress.

Some five years ago, the brothers Judet of Paris conceived the idea of removing the head of the femur entirely, and replacing it with one made of plastic. The substance used was methyl methacrylate. The stem of this prosthesis was reinforced by a bar of metal and the head itself was made to fit over a collar on the neck, fashioned with a special tool. This was a new principle and the procedure is now under extensive trial, the only variation being in the material employed. The latest substance to be employed is Nylon. No doubt prolonged observation will be necessary before there is universal acceptance of the structural material employed. In some parts of the country the method is so highly esteemed that even fresh fractures of the neck of the femur are being treated by immediate replacement of the fractured head by a prosthesis. This has the advantage of shortening the time of recovery. Time is not lost while waiting for the natural repair of the fracture, and the risk of non-union or of aseptic necrosis is by-passed. It may well be that this becomes the method of choice in certain types of fracture, even in the aged. In cases which have unfortunately undergone non-union or aseptic necrosis the Judet prosthesis would seem to be the most promising method of restoring function.

A large field is opened up for the treatment of deformities of the hip-joint, such as are caused by slipped epiphysis or by unreduced congenital dislocation of the hip. In most of these the situation is complicated by the fact that the acetabular

cavity as well as the head of the femur are deformed. If a femoral head of normal contour and proportions can be assured, the problem is to that extent simplified. The socket alone requires reconstruction, and that can frequently be accomplished.

Can this principle of substitution be applied to other parts of the skeleton? The attempt will undoubtedly be made. We can probably look forward to a similar treatment of the head of the radius, if that be thought desirable. One difficulty is that most bones have, in the neighborhood of joints, muscles and tendons attached to them. As far as I know the problem of fixation of muscles to a plastic prosthesis has not yet been tackled, but it does not appear to be insuperable. Perhaps the hospital of the twenty-first century will have a stock-room carrying spare parts for most of the twentieth century models. If that should prove to be the case, it is reasonably certain that most of these parts will be made of plastic.

Sex Crimes Follow Liquor Sales

Declaring that Beverage Alcohol may be responsible for one-half to nine-tenths of all sex crimes, the American Business Men's Research Foundation, in a review of current, scientific studies of the question, visualized the findings assembled in a graph which shows that the sex crime rate closely parallels the per capita consumption of absolute alcohol during the seventeen years, 1933 to 1950, inclusive. In 1949, according to F.B.I. figures, persons charged with rape and held for prosecution, per 100,000 population, totaled 9.47. Fifteen years ago the rate was only 5.5. 1949 record shows "sex offences (except rape and prostitution)" the rate to be 41.0. In 1933 it was only 17.2.

The latest statistics of the Uniform Crime Reports compiled by the F.B.I. reveal the following. The peak year of sex crimes was reached in 1945 and the 1946 figure was not much lower than the peak year. Similarly, the peak year in the consumption of absolute alcohol was in 1946 and the 1945 and 1947 figures were both only ten points lower.

Thus, the rate of sex crimes in 1946 was two and a half times that of 1933. In 1949 it was twice as much as in 1933 and still above the 1944 level.

In contrast, the 1946 consumption of absolute alcohol was triple that of 1934. The latest figure available, 1949, shows consumption of absolute alcohol is 2.6 times that of 1934 and still above the 1945 level.

The sex crime rate does not follow the general rate for all crimes. The crime rate for all crimes reached a peak in 1948—50 per cent more than in 1933.

Genito-Urinary

The Management of Anuria

A Review

R. M. Cherniack, M.D.*

When a patient suddenly ceases to form urine, or when the amount of urine formed abruptly decreases to a negligible quantity, he is faced with a most serious and very dangerous situation. Too often the condition will go unrecognized until complete anuria has developed. A careful check of the urinary output should be made on all operative and traumatic cases. I should like to emphasize to you that oliguria, with a low specific gravity—that is less than 1000 cc. of urine in 24 hours with a specific gravity of 1.012 or less, or any urinary output not exceeding 500 cc. as surely indicates renal damage as does complete anuria. On the public wards of this hospital it is now routine to chart the 24-hour urinary output on all operative and injury cases.

Joekes has divided the causes of anuria and oliguria into:

1. **Prerenal**—Any condition in which there is a prolonged fall in blood pressure below the level necessary to maintain glomerular filtration—as a result of blood loss, dehydration, or other forms of shock.

2. **Post-renal**—Where there is obstruction to urine flow in ureters, bladder or urethra such as stones or crystals in the ureters, Ca. bladder or B.P.H.

3. **Renal**—(a) Acute Glomerular Nephritis; (b) Bilateral cortical necrosis; (c) Acute Tubular Nephrosis.

Acute tubular nephrosis or lower nephron nephrosis is the term used to indicate a syndrome characterized by oliguria or anuria, heme-pigment excretion, azotemia, hypertension and uremia which may develop following transfusion reactions, shock or prolonged hypotension, burns, various types of injuries and numerous other causes. All these have in common varying degrees of damage to the epithelial lining of the kidney tubules, usually localized in the ascending part of Henle's loop and in the distal convoluted tubules.

The clinical course of lower nephron nephrosis can be divided into:

Shock or Reversible Phase

During which renal damage apparently occurs. Hypotension is present, the glomerular filtrate is affected, there is ischemia of the tubular epithelium

and damage occurs. With or without the initial period of shock, the patient may develop nausea, vomiting, malaise, and sometimes pain in the back.

This is a very short-lived period, lasting only a few hours at the most.

Anuric Phase

The stage of renal insufficiency. The patient may abruptly or insidiously develop anuria or oliguria. The urine specific gravity becomes fixed at a low range (1.005-1.012) and albumen, red blood cells, white blood cells, granular and heme casts are not infrequently found in the urine.

This period may last from 1 to 14 and even 21 days.

Diuresis Phase

This constitutes the early period of recovery, and may occur at any time, the urinary output suddenly reaching 1000 cc. and more.

There is then usually a period of prolonged renal convalescence and renal function may not return to normal for many months.

The reason why tubular necrosis causes anuria is still not definitely explained. The old concept of obstruction of tubules by necrotic material is only partially true and it is now known that due to the damage of tubular epithelium, all the glomerular filtrate is reabsorbed into the blood stream with resultant anuria. Thus, the old method of trying to flush the necrotic material out of the tubules is definitely the wrong management.

It must be emphasized that the use of large amounts of fluid is extremely dangerous for a patient with acute anuria, especially if given in the form of milk or saline solution, as he cannot eliminate either water or salts. Thus, this method tends to overfill the circulation and overload the patient with sodium chloride.

Management of Lower Nephron Nephrosis

The fatal outcome in this condition has been attributed to retention of a large number of substances with emphasis on protein breakdown products, but death usually results too soon for this to develop and is most commonly due to water retention, the patient dying of cardiac failure and pulmonary oedema. An important but less common cause is Hyperpotassemia, again resulting in myocardial failure.

Many methods of management have been recommended, but the best results in more recent years have been obtained with conservative management. This is directed towards keeping the patient alive until a spontaneous diuresis occurs. This may begin at any time. The renal injury is usually self-limited and remarkable restoration of

*Resident and teaching fellow in the Department of Medicine, Winnipeg General Hospital. Presented at the Post-Graduate Refresher Course, University of Manitoba, March 28, 1951.

function occurs if the patient can be tided over the critical period.

In any case of acute renal failure it is important to make an accurate diagnosis of the underlying pathology. Post renal obstruction must be excluded and removed if present. If sulfonamide crystal blockage is the cause, alkalinization of urine and washing out of ureters is necessary. In transfusion reaction renal damage may be avoided if a copious diuresis is maintained. The best diuretic is I.V. isotonic Sodium Sulfate. In Mercury Bichloride poisoning B.A.L. is immediately indicated.

In Shock Phase

When shock is present, blood transfusions, oxygen, intravenous fluids, etc., should be given immediately, for there is a safe period of only 2-3 hours.

In Phase II

The oliguric or anuric period—it is very important to understand that there is kidney damage and one must not force the kidney to do work that it is not capable of doing. An anuric patient cannot excrete water except in very limited amounts in breath, sweat and stool. In temperate climates this will amount to 750-1000 cc. If there is any vomiting, diarrhoea, or pyrexia, there will be a higher fluid loss.

Since death in these patients is usually due to water retention and overloading of the circulation, you must remember not to give the patient more water than he is losing. If the patient is anuric he should receive no more than 1000 cc. of fluid (by any route). If he is oliguric his intake should equal the total output (Urinary plus insensible loss).

If the patient is not vomiting and can tolerate a diet he should be given a high caloric diet containing carbohydrate and fat with no protein. Do not include protein because the nitrogenous metabolites such as urea, uric acid and creatinine cannot be eliminated. Moreover, Potassium which is an important factor in uraemia is also liberated during endogenous breakdown of proteins. A recommended manner of administering the ideal diet is to give a mixture containing 200 gms Glucose, 150 gm. butter and 1000 cc. of water through a Levine tube and allow this to drip into the stomach over a 24-hour period. This will give the patient 2000 calories a day and the maximum fluids allowed.

If the patient is vomiting and cannot tolerate a diet, he should be given 750-1000 cc. of 10-15% Glucose in water intravenously daily.

Do not give the patient any salt or saline solutions, as he cannot eliminate salts and he will be overloaded with sodium chloride.

If too much fluid or salt is given the patient will die of left heart failure, edema of lungs or brain and anasarca. Most patients with lower nephron nephrosis can easily survive the period of anuria or extreme oliguria provided the circulation is not overloaded with fluid and salt, and no food is given which causes production of toxic metabolites.

Mercurial diuretics or diuretic salts such as Ammonium chloride or Potassium nitrate are of no value at all and only make the condition worse.

Prophylactic Penicillin may be given daily.

Empirically vitamins may be administered.

If acidosis is apparent clinically give 100 cc. of 5% Soda Bicarb I.V. If any signs of heart failure develop—Digitalize the patient.

Diuretic Phase

Once the diuresis begins and exceeds 1 litre a day, the patient should be placed on a high caloric, low protein diet which should contain ample mineral salts. The intake should equal total output plus 1000 cc. During this great diuresis, sodium chloride may be excreted in great amounts, and salt should now be administered.

Summary

Lower nephron nephrosis is a syndrome of anuria and uremia which may result following operation, injury, drug poisoning, and many other conditions. The clinical course of this disease may be divided into three phases: the shock phase, the anuric phase, and the diuresis phase.

The management of this condition is most important and is different in each phase of the disease.

During the shock phase—Treat the shock with blood, oxygen, and intravenous fluids immediately.

During the anuric phase—Limit the fluid intake to 750-1000 cc.; do not give salt or saline solutions; try to give a high caloric diet containing carbohydrate and fat with no protein.

During the diuresis phase—Give fluids equal to output (urine plus insensible) and 1000 cc.; give salt or saline solutions.

Perirenal Abscess

Ward A. Shaver, M.D.

Resident Interne, Department of Pathology
Deer Lodge Hospital, Winnipeg, Man.

In the last nine hundred autopsies in Deer Lodge Hospital three cases of perinephric abscess have been encountered. The first two cases were caused by direct spread from adjacent suppuration in the contiguous kidney. The third case was due to metastatic spread from a boil in a poorly nourished old man. In none of the cases was the diagnosis suggested ante-mortem. Recognition of this condition is of great importance because of its serious nature if left untreated and because it often requires treatment of a type separate and different from that applied to the original lesion. A brief review of the main diagnostic points was then thought to be in order.

Case Report: A 78-year-old white male had been confined to hospital since February, 1951, because of weakness and leg pain attributable to a previous diagnosis of Prostatic Carcinoma made by gross appearance in October, 1946, from a transurethral resection, and by microscopic appearance in June, 1949. He was getting along well enough to be up and around the ward with considerable leg pain. On April 27, 1951, he developed a boil 1 cm in diameter, within his left nostril and on April 29, penicillin 300,000 units with 500 mg aureomycin daily was started. A septic fever to 103°, leucocytosis of 27,000 with 93% neutrophils and sed. rate of 76 mm developed. The patient died on May 6, 1951. At autopsy a left perirenal abscess with many large pockets was discovered. The kidney capsule was not broken and the parenchyma not grossly involved. There was terminal bilateral lobar pneumonia with abscess formation, as well as invasion of the right ureter by tumor with right hydroureter and hydro-nephrosis.

The term perinephritis may be used to designate any inflammation of the perinephrium or fatty capsule of the kidney which lies within the fatty capsule of Gerota. Two forms are recognized, the non-suppurative and the suppurative. The former is rare as an extensive lesion causing clinical symptoms and requiring treatment in itself but is quite common as small localized fibrous obliterations and adhesions of the fatty capsule often noted at operation on chronically infected kidneys. The suppurative form is also uncommon as a distinct clinical entity but is of importance because of its serious nature and because it may require recognition and treatment separate from that of the primary inciting lesion, whether that be in the kidney or in some adjacent organ, or from a distant focus.

Since the fibrous renal fascia of Gerota surrounds and limits the fatty capsule, this structure

usually forms the boundary of the inflamed area. The renal fascia forms a sac, shaped somewhat like an inverted pear or a flattened flask having a rather long neck directed downward. Its external surface is attached to the diaphragm above, to the psoas and quadratus lumborum muscles posteriorly, to the vertebrae medially, to the peritoneum anteriorly and to the flat abdominal muscles, with more or less subperitoneal or para-renal fat intervening, laterally and posteriorly. Besides the perirenal fat the main expansion above contains the kidney and kidney pelvis, while below, the neck like appendage gives a rather well marked sheath to the ureter and merges with the pelvic fascial planes which put it into relation with the pelvic organs as far down as the base of the bladder (Gerota). The anatomic arrangement permits the perirenal fat to become involved by extension in inflammations of any of these adjacent structures (vertebra, lungs, pleura, bowel, uterus, tubes, bladder, prostate). Extensive abscesses may also rupture into any hollow cavities and even onto the skin surface. Lesions of the kidney and ureter which lie within it may, of course, involve the perinephrium. Bacteria may also reach the perinephrium by metastasis.

Variable gross pathologic pictures are encountered. The entire fatty layer or parts of it may be found to be hardened, edematous, hemorrhagic and inflamed without any microscopic evidence of frank suppuration or pockets of pus may be found.

There are three recognized routes of infection. Hematogenous spread to the small end arteries in the peri-renal fat; lymphogenous spread, which is of uncertain mechanism; and direct spread from adjacent suppurative lesions. The common organisms are staphylococcus aureus, streptococcus, bacillus coli and the tubercle bacillus in the chronic form.

Signs of abscess formation are the dominant clinical findings with localizing signs of lumbar pain or tenderness, and lumbar mass. Fever is generally intermittent in the early stages and may be high. When the abscesses become large and involve nearby structures the fever usually becomes continuous. The leucocyte count is high.

Pain is located in the flank or abdomen of the side affected. It is generally dull and indifferent in character. Tenderness will be present in the superior lumbar triangle or over the mass if one is present. Bending the body to the side away from the abscess may produce pain while bending toward the side is usually painless (Foulds). The thigh on the affected side may be flexed, adducted and rotated inward. Postural changes may be so marked that disease of the hip, sacroiliac region or spine is diagnosed.

Lumbar mass may be present early if the abscess is at the lower pole, well below the ribs,

but if it is behind the kidney or near the upper pole the rigid costal cage may prevent its palpation. The high incidence of mass in reported cases is probably due to understandable tendency on the part of the surgeon to await this sign before making a definite diagnosis and operating.

In extra-renal abscess the urine is generally normal except for toxic albuminuria and cylindruria.

X-ray findings can be of great importance in diagnosis particularly when assembled and correlated with the clinical symptoms and signs. Although no single X-ray sign is altogether characteristic of perinephritis the various signs as a group amplify the study so that the diagnosis may be made with considerable confidence. The plain X-ray may show a mass, obliteration of the psoas muscle shadow, or lumbar scoliosis with concavity toward the affected side; urographic study may reveal deformities of the kidney pelvis and fixation and displacement of the kidney or ureter.

A mass which is not palpable may be visible on the X-ray film. However, even a large mass may not cast a sufficiently dense shadow to be recognized. A very important sign is scoliosis of the lumbar spine with concavity to the affected side. It appears to be due to a contraction of the longitudinal muscles in an attempt to reduce pain by splinting the spine. It may perhaps be due to an instinctive effort to increase the loin space. This is seldom seen in patients with other loin or kidney conditions without peri-renal infection. Even cases quite early with small abscesses will show this sign. This appearance may be simulated by faulty positioning of the patient. Fixation or curvature of the spine by arthritis may prevent the development of this sign or a convexity to the affected side may pre-exist.

Obliteration of the psoas shadow on the affected side is due in part at least to increased radiopacity of the inflamed contents of the renal fascia and is generally associated with the presence of the shadow of a mass on X-ray. It may also fail to be shown by faulty preparation of the patient or because of poor technique in making the film and

its obliteration may be noted in other retro-peritoneal and abdominal conditions.

The pyelogram itself may be normal or may present irregularities or deformities in perinephritis both with and without abscess. In the primary variety the pyelographic changes are neither constant nor of great significance. When present they usually take the form of obliterations or slight changes in one or more of the minor calyces near the abscess cavity, or alterations in the major calyces may indicate pressure from without. A tract communicating with the pelvis and a collection of opaque material in the peri-renal space is said to be pathognomonic for peri-renal abscess (Kerr and Gillies).

Pyelography may also reveal displacement of the kidney or ureter. The A-P film will show lateral shift, or rotation and the lateral film will show anterior displacement. Displacement of the kidney may be present in other conditions but is of significance when found in conjunction with concavity of the spine to the suspected side and other suspicious signs.

Fixation of the kidney may be demonstrated. If two pyelograms are made or a double exposure on one film, one at full expiration and one at full inspiration or with the patient lying and standing, one may demonstrate this feature. Since the kidney normally has considerable gliding motion within the renal fascia, extensive inflammation of the fatty layer may limit mobility materially.

Summary

A brief review of the diagnostic features of perinephric abscess with emphasis of radiological signs has been offered. The condition might well be kept in mind in cases where signs of sepsis develop particularly if a skin infection had been present and if the patient was in a poor nutritional state.

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Treatment of Male Sterility

Melville J. Swartz, M.D.
Mall Medical Group

During the past ten to twenty years it has become increasingly evident that in 35 to 60% of barren marriages the male is at fault. Discounting any functional disorders which may be present, we find the sterility due either to the absence of spermatazoa or the presence of abnormal spermatazoa. This fault is the result of either:

1. Secretory disorders of the testes, or
2. Excretory or obstructive disorders of the male reproductive system.

The secretory disorders denote an injury to the testes, usually due to some type of orchitis, mumps being the most frequent cause. In this type we find changes such as:

1. A decrease in the numbers of spermatazoa with oligospermia or azoospermia.
2. A change in the morphology of the spermatazoa.
3. A definite modification in the type of spermatazoal motility.

The above pathological changes definitely influence any disposition on the part of the spermatazoa to fertilize or the ovum to become fertilized by these abnormal spermatazoa. At present little can be done to improve the secretory type of infertility. The excretory disorders, on the other hand, even with bilateral obstruction of the vasa deferentes, have a much more favorable prognosis if we appreciate the fact that the mechanical obstruction can be removed. And it is the removal of this type of obstruction, and how to provide a patent vas, with a passageway for the spermatazoa, with which this paper deals.

The commonest recognized cause for the excretory or obstructive type of disorder is gonorrheal vaso-epididymitis, and fifteen per cent of all cases of azoospermia are due to bilateral vasal obstruction, the result of gonorrheal vaso-epididymitis. Eight per cent of all oligospermias are due to unilateral obstruction of the vasa, the result of the same pathological process. Gonorrheal epididymitis is of particular concern to us, as it has for a corollary in most cases the fact that there are living, active motile spermatazoa in the head of the epididymis. Many cases have been reported years after obstruction was first recognized, in which biopsies showed normal testicular tissue and spermatazoa present.

Trauma is an etiological factor in eighteen per cent of male infertility, producing bilateral obstruction in twelve per cent of cases, and unilateral obstruction in four per cent. Other types of epididymitis such as those caused by *Bacillus Coli* and *staphylococci* do not seem to produce the same type of epididymal or vasal damage as those of the Neisserian organism.

With such observations it was a natural outcome for urologists to consider avoiding the obstruction and rerouting the seminal flow by anastomosing the vas deferens to the head of the epididymis. By this means might be re-established the continuity of flow of spermatazoa from the testicle to its normal conclusion. Credit for the original work and operations on the reconstruction of the obstructed channels must be given to such men as Gosselin, d'Humbert, Delbert, and Chevassau. The first operations were done by inserting the patent part of the vas into the head of the epididymis. Later operations, and the one most widely carried out today, is the side-to-side anastomosis, which is more logical in view of the fact that the vas is a contractile muscular tube, and there is less chance of any disturbance of its contractibility and movement in a side-to-side anastomosis, than there is in an end-to-end anastomosis.

The usual case which appears is that of a man married for some time and without children. A complete examination of the wife may or may not be done first. We prefer to leave the thorough check of the wife till that of the man is completed. The reasons for this are (a) it is far easier to examine the man to determine the presence of azoospermia or oligospermia, than it is to decide whether or not the wife is at fault. (b) The fact that we know at least fifty per cent of barren marriages is due to the husband. A thorough examination, including a semen examination should be done first. The examination may result in the finding of an azoospermia and the question which next arises is whether or not we are dealing with an azoospermia due to bilateral vaso-epididymal obstruction. In determining the actual location of the obstruction, we must always bear in mind the possible involvement of the ejaculatory ducts, and hope that the obstruction is in the epididymis rather than at the ejaculatory ducts.

Most cases are not that of a straightforward azoospermia. Usually we find the more complicated type of case such as an oligospermia, with complete obliteration of the epididymis on one side and the other testicle congenitally atrophied or undescended. Here we have one patent and one obliterated vas, and one functioning and one non-functioning testicle, the trouble, of course, being that the normal testicle is on one side and the normal vas on the other. In such cases we might be able to cure the oligospermia and azoospermia if we can connect the two normal structures. It is worthy of note that the gonococcus will rarely, if ever, produce an epididymitis of an atrophic testicle.

Where we cannot determine definitely whether the disorder is one of an excretory or secretory nature, we must, of course, resort to testicular and epididymal biopsy at a direct examination. This will give us information such as the true value of

the testicle, and whether we can ever expect it to function normally.

The actual operative type of biopsy is far superior to the needle biopsy. One is able to gather a great deal more information by direct examination and exploration of the head of the epididymis, if necessary, to determine the presence of normal spermatazoa in favorable cases, the absence of them in epididymal sclerosis, or to demonstrate a few abnormal non-motile spermatazoa in certain testicular injuries.

It is most desirable to attempt to re-establish the passage of normal productive spermatazoa, but in the presence of abnormal forms, or dead spermatazoa, vaso-epididymal anastomosis is unnecessary, as fertilization will not occur.

Having determined the presence of spermatazoa of one sort or another in the epididymis, if we are dealing with an azoospermia, the answer is obstruction in some part of the vas or epididymis. In such cases we examine the patency of the vas by injecting some colored fluid into the vas by means of a special trocar, noting whether this colored fluid passes out through a catheter in the bladder. In such cases, the patency of the vas being assured, we carry on with a vaso-epididymal anastomosis.

I have noticed invariably that whenever the suggestion is made of testicular biopsy or vaso-epididymal anastomosis, the less informed of the profession will regard the suggestions with quiet disdain, as only slightly removed from quackery. But in fifty per cent of these cases there has been a reappearance of spermatazoa with successful impregnation. We also believe that if the first attempt at creating a patent passage does not succeed, we should try again, and it is for that reason that the incising of the head of the epididymis is done with minimal trauma to allow areas for future anastomosis if the first is unsuccessful. In cases of complete obliteration of both vasa, and with normal spermatazoa in the head of the epididymis, an attempt can be made to artificially impregnate the woman from this source. The ovulation date must coincide, of course, with the date of the testicular and epididymal biopsy and investigation.

We have done vaso-epididymal anastomosis on nine cases of azoospermia, due to post-gonococcal bilateral vaso-epididymitis in six cases, and unilateral gonococcal vaso-epididymitis with either an atrophic testicle or an undescended testicle which had been removed on the opposite side. In five of these we have had success as far as the reappearance of spermatazoa, and in three we have had successful pregnancies. At the writing of this article we are awaiting the results of a pregnancy from our latest case, which was one with post-gonococcal epididymovasal obstruction with the opposite testicle removed twelve years before due to undescend.

The A B C of Vitamins

A

Oh fine and fat was Ralph the rat,
And his eye was clear cold grey.
How mournful that he ate less fat
As day succeeded day,
Till he found each cornea daily hornier,
Lacking its Vitamin A.
"I missed my Vitamin A, my dears,"
That rat was heard to say,
"And you'll find your eyes will keratinize
If you miss your Vitamin A."

B

Now polished rice is extremely nice
At a high suburban tea,
But Arbuthnot Lane remarks with pain
That it lacks all Vitamin B,
And beri-beri is very, very
Hard on the nerves, says he.
"Oh take your Vitamin B, my dears,"
I heard that surgeon say;
"If I hadn't been fed on standard bread,
I shouldn't be here today."

C

The scurvy flew through the schooner's crew
As they sailed on an Arctic sea.
They were far from land and their food was
canned,
So they got no Vitamin C.
For "Devil's the use of orange juice,"
The Skipper 'ad said, said he.
They were victualled with pickled pork, my
dears,
Those mariners bold and free.
Yet life's but brief on the best corned beef
If you don't get Vitamin C.

D

The epiphyses of Jemima's knees
Were a truly appalling sight;
For the rickets strikes whom it jolly well likes
If the Vitamin D's not right,
Though its plots we foil with our cod-liver oil
Or our ultra-violet light.
So swallow your cod-liver oil, my dears,
And bonny big babes you'll be.
Though it makes you sick it's a cure for the
rickets
And teeming with Vitamin D.

E

Now Vitamins D and A, B and C,
Will ensure that you're happy and strong;
But that's no use; you must reproduce
Or the race won't last for long.
So Vitamin E is the stuff for me,
And its praises end my song,
We'll double the birth-rate yet, my dears,
If we all eat Vitamin E.
We can blast the hopes of Maria Stopes
By taking it with our tea.

Apologies to Author, Unknown.

Case Histories—Surgical

Severe Dysmenorrhoea Cause Unknown

Presacral Neurectomy

S. S. Peikoff, M.D. F.R.C.S. (Ed.)
F.R.C.S. (C.), F.A.C.S.

This is the sixteenth of a series of Case Histories which will appear in the Review each month. The purpose of these publications is not to present rare or unusual cases but rather to consider the routine management of common surgical cases.

Case No. 44-8490. Miss L. R., St. Boniface Hospital. Color, white. Age, 20 years. Occupation, school teacher. Date of admission, July 27, 1944. Date of operation, July 31, 1944. Date of discharge, August 8, 1944. Complaint on admission, severe dysmenorrhoea.

Present Illness

About two years ago (1942), she began to experience severe abdominal cramps with her menstrual periods. Each ensuing period became progressively more uncomfortable. Just after the onset of the flow, the pain would come on with gradually increasing intensity. The pain radiated down the legs and was associated with frequency and backache. The following day the severity decreased but she suffered continuous soreness and backache. After about 6 months of these episodes, she developed a sudden pain in her right lower quadrant with nausea, which lasted for about two days. She called a doctor and had her appendix removed. Since that time she had, in addition to her other pains, attacks of right lower quadrant pain, each lasting a couple of hours. Her appetite was good, there was no dyspepsia, vomiting, diarrhoea or blood in the stools. Between periods she had complete relief. Being a school teacher, she had to stop work for 2 or 3 days each month. She intimated that some of her students embarrassingly predicted the time of her illness; on each occasion she had to go to bed for at least 1 and often 2 days during each period, and this interfered with her work. Heat, aspirins, Frosst 292, and other analgesics have only relieved her pains temporarily. She appeared in the office in a high state of nervous instability and depression.

Inventory by Systems

Eyes—Vision good. No diplopia or blurring.
Ears—Hears well. No tinnitus or vertigo.
Respiratory—Infrequent colds and sore throats.
No chest pain. No expectoration, dyspnoea or haemoptysis.
Cardio-vascular—No history of rheumatic fever.
No palpitations. No substernal pain. No dyspnoea.
Gastro-intestinal—See present illness.

Genito-urinary — Frequency during menses. No nocturia. No burning on micturition. No haematuria.

Menstrual—Menarche 14. 1. m.p. July 21-26, 1944. Duration 5 days. Interval 4 weeks. Severe dysmenorrhoea since 1942. No discharge.

Nervous system—Sleeps well. Headaches during menses. Irritable and nervous, particularly during menses.

Metabolic—No loss of weight. No heat or cold intolerance.

Past History

Appendectomy, 1943. Measles in childhood. No history of Tb., Ca., allergy or accidents.

Family History

Father—Killed in accident at age 50.

Mother—Age 53, alive and well.

No sisters or brothers.

No family history of Tb., Ca., diabetes, etc.

Physical Examination

A thin, under-nourished, pale, intelligent young female who appears to be in fair general health.
Head and Neck:

Cranial nerves—Intact.

Eyes—Lids and conjunctivae normal. No ptosis or exophthalmos. Pupils equal and react to light and accommodation. Fundi normal.

Ears—Canals and drums clear.

Nose—No obstruction. No pus.

Lips—Good.

Gums—Good.

Teeth—Much caries.

Tongue—Numerous fissures and raw looking.

Throat—Tonsils out. No congestion or post-nasal discharge.

Larynx—Both vocal cords appear normal.

Neck—No cervical lymphadenopathy. Thyroid not palpable. No abnormal pulsations.

Chest:

Heart—Apex beat in 5th interspace $3\frac{1}{2}$ inches from midline. Rhythm regular. Rate 68 per minute. No murmurs. Blood pressure 120/70.

Lungs—No deformity of chest wall. Movements equal and symmetrical. Tactile fremitus good. No dullness on percussion. Breath sounds normal. No adventitious sounds.

Mammae—Small and firm, and underdeveloped. Nipples and areolae normal. No tenderness or masses.

Abdomen—Contour normal; flat and relaxed. Tenderness on moderately deep palpation in right lower quadrant but no guarding or rigidity. Liver and spleen not palpable. No masses palpable. No hernia. Abdominal reflexes present and equal.

Vaginal examination — Not done (patient a virgin).

Rectal examination—Sphincter tone good. No fissures, fistulae or haemorrhoids. Uterus feels small but is in normal position. No masses in pelvis.

Extremities:

Upper—No deformities. Movements good. No clubbing of fingers. Reflexes all active and intact.

Lower—No deformities. Movements good. No varicosities. No oedema. Reflexes—all active and intact.

Spine—Movements in all directions unrestricted. No tenderness on percussion over spine.

Clinical Laboratory

Urinalysis—Color, clear, straw. Reaction, acid. specific gravity, 1.030. Albumin, 0; sugar, 0. Microscopic, negative.

Blood Count—Red blood cells, 3,670,000. Hemoglobin, 85%. Color index, .9. White blood cells, 4,600. Polymorphonuclear neutrophils, 48%. Small and large lymphocytes, 52%

Chest X-ray—Bony thorax is normal. Heart and great vessel shadows normal. Lung fields are clear.

Pre-operative Diagnosis

Primary dysmenorrhea (severe).

Indications for Operation

Operation was advised primarily to relieve the patient of her dysmenorrhoea. This patient had been to several doctors who tried in vain to relieve her of her dysmenorrhoea by advising general hygienic measures, exercise, and by prescribing sedatives, analgesics and hormonal preparations. The patient said she "would give anything if I could get rid of my painful periods." It was felt that presacral neurectomy might be the answer to the problem.

Pre-operative Care

The patient being in good general health, and in a good state of hydration and nutrition, no special pre-operative measures were necessary.

Detailed Description of Operative Technique and of Operative Findings

Patient placed in a high Trendelenburg position. Abdomen painted with merthiolate and draped.

Incision—midline sub-umbilical extending upwards and to the left of the umbilicus for about an inch and a half. Skin towels applied. Automatic retractors inserted. Small intestine was packed off to the right and the sigmoid to the left so as to expose the following landmarks: bifurcation of the aorta, the right common iliac artery, the left common iliac vein, the right ureter crossing the iliac artery, the promontory of the sacrum, the mesocolon of the sigmoid to the left. The entire area was well exposed. The posterior peritoneum was picked up by 2 Allis forceps just below the promontory of the sacrum. An incision was made commencing at the aortic bifurcation and extending downwards and over the promontory of the sacrum for about 3 inches. A long suture was

inserted into each leaf of the peritoneal incision and haemostats applied to each and left hanging over the side of the wound so that the weight of the haemostats acted as retractors. The presacral nerve could now be felt as a ridge over the promontory of the sacrum. This was hooked up on a tenaculum and lifted off the sacral promontory with considerable tension, so that the 2 hypogastric nerves along with the various fine branches could be palpated with the fingers. Dissection was begun at the right common iliac artery dividing all the various branches with sharp and blunt dissection, including all the connective tissue lying on the pelvic wall from the right ureter working towards the left common iliac vein. The middle sacral artery was not ligated. The presacral nerve was now clamped about 1 inch above the aortic bifurcation while distally both hypogastric nerves were ligated just above the bladder. The nerve appeared to be very well formed instead of the more usual plexus formation. The ends were ligated with chromic catgut 000. The posterior peritoneum was sutured with continuous chromic catgut 000. The abdominal incision was closed in layers; the peritoneum was closed by continuous suture catgut i; the rectus sheath by interrupted chromic catgut i; and the skin by interrupted silkworm gut.

Anaesthetic

Pre-medication—Nembutal gr. iss h.s. and in the morning. Morphine gr. 1/6 with atropine gr. 1/150 one hour pre-operatively.

Condition of patient—Temperature 98°F. Pulse 68. Respiration 18. Blood pressure 120/70.

Unfavorable features—None.

Agents—Spinal, using 135 mg. metycaine in 4 cc. spinal fluid. Oxygen by mouth hook.

Stimulants—Ephedrine gr. ¾.

Hemorrhage—None.

Post-operative condition—Good.

Gross and Microscopic Description of Tissues Removed

Approximately 2½ inches of tissue, having the appearance of a nerve trunk.

Microscopic—Definite nerve tissue.

Final Diagnosis

Severe dysmenorrhoea, cause unknown.

Progress Notes Including Post-operative Care During Stay in Hospital

July 31, 1944—Returned to ward from operating room condition appears good. Pulse 80, respiration 20, blood pressure 100/65. Morphine gr. 1/6 given as necessary for pain. CO₂ hyperventilation given q.i.d. Spent a good post-operative day and night.

August 1, 1944—Temperature 99.2°F. Pulse 84. Respiration 20. Condition good. Complaining of gas pains. Rectal tube inserted with relief.

August 2, 1944—Temperature 100.2°F. Pulse 86. Respiration 20. Condition good. Saline enema

given. Allowed up out of bed, and walking. Started to bleed per vagina in moderate amount. Condition very good. Temperature, pulse and respiration remained normal during remainder of post-operative course.

August 7, 1944—Sutures removed. Wound looks healthy.

August 8, 1944—Discharged from hospital, feeling well.

Condition on Discharge

Recovered from operation.

Cannot estimate result for a few months.

Follow-up Notes Since Leaving Hospital

September 21, 1944—Feeling well. Had a menstrual period from Sept. 9 to 12 and felt absolutely no pain. Very pleased with result. No pain in right lower quadrant.

Nov. 11, 1944—Had a period from Nov. 3 to 7, and had absolutely no pain. Period normal in all respects.

September 24, 1945—Has had no pain with any of her periods since operation. "Thrilled" with her result. Periods still somewhat irregular, coming every 3 to 5 weeks, but are otherwise normal in all respects. Still has no right lower quadrant pain.

May 30, 1949—Patient confined at St. Boniface Hospital. The course of the pregnancy and labor is particularly interesting. The L.N.M.P. was on Oct. 1, 1948, making the expected date of delivery July 8, 1949. The prenatal course was essentially uneventful. On May 30, 1949, the patient called to say she had noticed bright red blood per vagina, and was advised to go directly to hospital. A rectal examination at the hospital on admission revealed 3 fingers dilatation of the cervix—and this with no suggestion of true labor pains. Two hours later the patient was delivered of a normal female child weighing 5 pounds 10 ounces. True labor pains were at no time experienced—the only discomfort felt was when the head was coming through the perineum.

June 12, 1950—No discomfort with menses.

Radiology

Intestinal Gas Patterns in Intestinal Obstruction

Ward A. Shaver

Resident in Radiology, Deer Lodge Hospital

An important role in the diagnosis and treatment of intestinal obstruction both in adults and children is played by information obtained from the appearance of intestinal gas in roentgenograms of the abdomen. To clinicians, a clear understanding of certain normal variations and also of the typical x-ray patterns of types of obstruction is of great importance. The roentgenographic manifestations of intestinal obstruction are abnormal air in the intestines, the distribution of that air and distention of the bowel with fluid levels in more advanced cases. The radiograph may also reveal free air when the obstruction is paralytic in type due to a ruptured viscus or peritoneal fluid may be seen in cases of peritonitis.

Gas is normally present throughout the intestinal canal appearing in the stomach, duodenum and jejunum within a few minutes of birth (6 to 15 mins.) and passing within four to six hours into the sigmoid colon or rectum. Paine and Nessa have shown that up to eighteen months of age, gas is equally distributed between the small intestine and the colon; between eighteen months and six years less and less gas is seen in the small bowel; after seven years no gas is normally visualized in the small bowel. Roentgenograms in this young age group, particularly where obstruction is suspected, require careful interpretation.

In cases of obstruction the amount of gas present in the small bowel will be larger than normal and the diameter of the gas-filled coils will be greater. The knowledge of the rapid transport of the gas is important when congenital atresia may be present, since gas should reach the sigmoid colon in six hours. In atresia of the rectum or imperforate anus the gas bubble may be useful in measuring the length of the defect after the method of Wangenstein and Rice.

In the older child and in adults, under normal conditions, gas is visualized in the stomach and colon only, the sites where intestinal contents remain for some time. In the small intestine the rapid rate of transport so admixes the gas and fluid contents that gas is not visualized. Under conditions of stasis the gas and fluid separate out and the gas is visualized.

The contents of an obstructed bowel then consists of fluid and gas which are present in varying amounts. The amount which each contributes varies, but on the whole, the longer the duration of the obstruction the greater is the fluid content. Acute obstructions are usually gaseous in character. Wangenstein has shown that the source of the gas is 10% from digestive processes, 22% due to diffusion of blood gases into the lumen, and 68% due to swallowed atmospheric air. The air swallowing appears largely connected with respiration and the negative intrathoracic pressures so induced. In obstruction fluids normally dumped into the intestinal tract seem to be increased in amount. These are known to be large in amount, normally,

according to Rowntree, 7,000 cubic cms., while Gamble estimates 8,200 cubic cms. per day. In high obstructions the early vomiting causes great loss of fluid and therefore fluid does not contribute so much to the distension of these cases.

There are essentially two varieties of obstruction:

1. Simple obstruction, in which continuity of the bowel alone is interrupted. This may be organic or paralytic.

2. Strangulating obstruction, in which the blood supply is also compromised. Venous return is first cut off, the bowel becomes dark blue in color and as the arterial supply interference develops, necrosis and gangrene of the bowel wall occur with passage of intestinal bacteria through the wall into the peritoneal cavity causing peritonitis.

The roentgenogram is valuable both for the diagnosis of an intestinal obstruction and for information regarding the degree, extent and location of the obstruction by examination of the distended coils. The roentgen diagnosis in obstructive cases depends upon the dilatation of the bowel and the accumulation of fluid and gas. Gas in the lateral borders of the abdomen is ordinarily limited to the colon, the long axis is usually vertical and the intestinal walls are thicker and haustral markings are frequently in evidence. Gas in the small bowel is characterized by its central location, the long axis of the shadow is usually transverse and, when loops are considerably dilated, the two intestinal walls separating loops are seen to be thin and narrow. The occurrence of a fairly thick wall, separating greatly distended loops, suggests the presence of fluid or exudate between them. In the ileum, the valvulae conniventes are less prominent than in the jejunum; in consequence, distended coils of ileum are more blank and somewhat characterless as contrasted with the feathery appearance of distended jejunum coils and the haustral markings of a distended colon. The feathery appearance of the distended jejunum may, in certain cases, be imitated so closely by distended colon, as to preclude absolute differentiation, and a barium enema may be necessary to distinguish them.

The interpretation of gas patterns in the G.I. tract has become fairly well standardized. When the small intestine is seen to be distended without any gas being found in the colon, that is considered to be evidence of small bowel obstruction. The absence of gas in the colon is of considerable diagnostic significance in a case of this type. It is assumed, of course, that a preliminary enema had not been given before the film was taken. If the cause of the distension is paralytic, then gas may be seen throughout the bowel including the colon. In a case of colon obstruction, gas is seen around to the site of obstruction but no further; the small bowel may or may not show distention depending

upon the patency of the ileo-colic sphincter and valve. A colonic obstruction may be converted into a closed loop obstruction and perforation may occur without vomiting, by a tight ileo-colic valve and sphincter. Whereas, the radiologist can ordinarily effect entry into the small intestine by barium enema one must recall that the pressures being used (which are ordinary in excess of a height of 90 cms. and with a heavy barium suspension) are far in excess of the greatest pressure measured in 5 cases of clinical obstruction by Wangenstein. The highest pressure was 52 cms. of water and such pressures rarely exceed 25 cms. of water. Furthermore, the radiologist employs manipulation of the bowel and there is undoubtedly a vast difference between the rapid distention of the colon by an enema in its effect on the ileo-colic valve than the gradual increasing pressure of an obstruction. The appearance of thickening of the bowel wall owing to edema of the bowel wall and transudation of fluid into the peritoneal cavity may occur in simple, but more often in strangulating obstructions, as well as in peritonitis.

Distended loops of small bowel may be further localized as to anatomic situation according to the studies of Mall. The arrangement of the small bowel into six primary groups of coils is recognized both in the embryo and adult. The first coil forms the duodenum, and due to its relative fixation and generally constant shape is readily recognized when filled with fluid or gas. As the intestine leaves the duodenal-jejunal flexure it forms the second group of coils which lie in the left hypochondriac region. At the distal end of this group, and in fact, at the end of each group, the intestine loops into the root of the mesentery and then out to the next group. The third group of coils lies in the left lumbar region, the fourth, in the umbilical and right upper hypogastric region. The fifth group is usually found in the right iliac region and the sixth group in the lower hypogastric region and pelvis, the terminal loop ascending from the pelvis to enter the caecum. Within each group the loops of bowels are also characteristically arranged. In the second and third groups they lie transversely and in the fourth, fifth and sixth groups the coils lie vertically.

There are several methods of making the roentgenogram and they are of great importance in interpretation. The average x-ray technician tends to place the film too low and care should be taken that the lower edge of the film is only one or two cms. below the anterior superior iliac spine. The patient must not have had an enema prior to the examination as it will interfere with the gas pattern of the colon and prevent reliable interpretation. Whether or not obstruction is complete may be determined by air persisting in the colon after evacuant enema.

(a) The supine position gives the best informa-

tion as to the pattern of arrangement of the distended intestinal coils, even though the distended loops will appear larger than they really are.

(b) In the prone position a more accurate diameter of the coils is obtained but owing to pressure on the coils their arrangement may be disturbed.

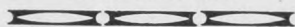
(c) Films in erect or lateral position permit visualizing fluid levels but the exact location or actual degree of distention cannot be determined.

The radiograph is valuable in regard to treatment mainly in two ways: Firstly, by its localizing value it indicates the probable site of obstruction and gives the surgeon some idea of where the incision should be made to best advantage and also where he should first look for the obstruction. Secondly, it distinguishes those cases of simple obstruction, complete or incomplete, which may safely be treated for a time by decompression without immediate operation, from those cases requiring immediate operation, i.e., those with a strangulating obstruction or great distention of an obstructed colon. Simple obstructions treated by suction must be carefully followed by repeated x-rays as relief of symptoms will not always mean the obstruction is relieved.

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Cancer



Abstract

Laszlo, Daniel; Colmer, Malcolm L.; Silver, G. B.; Standard, Samuel. *Errors in Diagnosis and Management of Cancer*, Ann. Int. Med. 33: 670-689, 991-1007, 1950.

Twenty cases, who were admitted to Montefiore Hospital, N.Y., were analyzed and were divided into three categories.

Group I consisted of eleven cases, in which cancer was diagnosed, but was not present.

Group II consisted of five cases, in which terminal cancer was diagnosed, and curable cancer was present.

Group III consisted of four cases where visible cancer was present, but was undiagnosed.

In all of these groups, there was a tendency to perpetuate an original incorrect diagnosis without re-assessment of the case.

In analyzing the factors in Group I, the following types of error were noted:

1. Omission of biopsy in three cases—in one of these a woman was diagnosed as having inoperable carcinoma of the recto-sigmoid with pelvic metastases. Five and one-half years later her symptoms of obstruction were found to have been due to a meningioma of the cord and the pelvic mass—inflammatory in nature—had disappeared.

2. Misinterpretation of gross pathology at operation was found in five cases. The most common error here was the mistaking of inflammation for cancer.

3. Errors in histological diagnosis in three cases. One of these was the confusion of a papilloma with a papillary carcinoma of the urinary bladder. The other two errors were probably due to insufficient or incorrect clinical information.

4. Errors in roentgen ray diagnosis were present in four cases. In one of these cases, incorrect clinical diagnosis of carcinomatosis with ascites was supported in a case of papillary serous cystadenoma of the ovary. In the other cases there was a tendency to use the roentgen ray as the sole means of diagnosis, rather than as an aid to diagnosis.

5. Surgical exploration was omitted in two cases—a pernicious anemia with atrophic gastritis was labelled inoperable gastric carcinoma, and a hydronephrosis was called an inoperable retroperitoneal tumor.

6. Pertinent diagnostic aids were not used in three cases. These included such simple and routine procedures as blood examination, rectal examinations, and sigmoidoscopy.

In Group II the errors were somewhat similar to those in Group I.

1. Again inflammation was mistaken for hopeless extension of cancer in three cases.

2. Histological diagnoses were wrong in two cases. One of these was probably due to inadequate clinical examination accompanying a needle biopsy. In the other case a benign polyp of the rectum was called adenocarcinoma, and the case was labelled carcinoma of the rectum, metastatic to lung and spine. Three months later the case was reviewed and investigation revealed it to be a bronchogenic carcinoma with a benign polyp of rectum, and a healed compression fracture of a vertebra—the history of the old fracture had been elicited but ignored.

3. Misinterpretation of roentgen ray was found in the case of the old compression fracture mentioned above. Here again lack of clinical information probably prevented a correct interpretation.

4. Failure to interpret physical findings correctly and lack of surgical exploration were factors in a case of tumor of undescended testicle. The absence of a testicle, with the presence of a lower abdominal mass on the same side, should certainly bring to mind the dictum that undescended testi-

cles are twenty times more prone to tumor formation than are normal testicles.

In Group III all of the cases were characterized by a failure to re-assess at reasonable intervals, and a failure to biopsy obviously suspicious skin lesions. All of these lesions were on the ankles. In two cases they were thought to be varicose ulcers, and in the other two cases the cancer had developed in areas with long standing chronic atrophic dermatitis. These cases stress the importance of taking biopsies from suspicious skin lesions even though they are not in the usual cancer bearing sites—especially when these lesions do not respond to treatment.

Georgina Hogg, M.D.

The Canadian Red Cross Blood Transfusion Service

May, 1951

Name of Hospital	Total Patients Transfused	Total Bottles Used
Winnipeg General	362	590
St. Boniface	221	366
Misericordia	108	150
Grace	145	181
Deer Lodge	38	66
Children's	31	34
Victoria	42	62
Concordia	22	39
St. Joseph's	45	74
Municipal	5	8
Shriner's	4	4
Brandon General	34	44
Portage la Prairie General	14	20
Selkirk General	13	33
McKellar Hospital, Ft. William	65	84
General Hospital, Pt. Arthur	73	83
St. Joseph's, Pt. Arthur	42	48
Others	60	111
Totals	1326	1997

Comments

This is my last report as Director of the Manitoba Depot and I will leave you with a report of the blood bank situation at this time. The use of whole blood in the area served by the Winnipeg Depot has increased progressively over the last 18 months from about 900 bottles a month to 2,000 bottles a month. In part this has been due to the servicing of more and more points outside Winnipeg. We are now in fact supplying every hospital in Manitoba and northwestern Ontario, with the exception of one or two small places in Manitoba and two or three in northwestern Ontario. In part, however, the increased consumption is

due to increased amounts by the hospitals in the city of Winnipeg. From the 900 bottles used in Winnipeg during our first month of operation, there has been a steadily rising demand until now it takes nearly 1,500 bottles every month to satisfy all requests by the Winnipeg hospitals.

From all quarters there is no slackening of the tendency to use more and more blood. On the donor side we are at present in the position, with but rare exceptions, to meet all demands. Certainly there is absolutely no doubt of our ability to comply with all requests in cases where blood may mean the difference between life and death. It is, however, inevitable that from time to time a relative shortage develops when less urgent and postponable requisitions cannot immediately be filled. To meet such a contingency I have invited all the major city hospitals to form a small committee whom we should notify when such a contingency arises and such committees now exist in in most of the large Winnipeg hospitals. These committees too, can serve by bringing to the medical director's attention any complaints there may be about the service and they can receive any requests by the medical director of the blood bank for co-operation by the hospitals where such co-operation would assist the maintenance of an unbroken supply of blood. For example, the over-ordering of blood remains a grave matter. In May roughly 2,600 bottles were issued cross-matched for individual patients and of this number, no less than 1,000 were returned unused. I have said it before and I can but repeat that this degree of over-ordering is out of all proportion and reflects it seems to me, upon the ability of the surgeons and physicians to estimate requirements for individual cases. I have spoken strongly because the problem is serious and should no easing of the position occur, smooth operation of the blood bank is in very real danger.

Apart from this fact all has gone smoothly during my tenure of office in Winnipeg and I would like publicly to express my deep appreciation of the co-operation, courtesy and hospitality shown to me by doctors, both in the city and the country. It has made my stay in Manitoba very pleasant indeed. I leave you with a Parthian shaft—because of the holiday season donors during July and August will be a little more difficult than usual to entice into blood clinics and, therefore, it is probable that a slight falling off in the supply of blood will occur during those months. I trust you will co-operate with my successor, Dr. George A. Large, in his job of taking over the depot at such a time.

Cecil Harris, B.Sc., M.D., M.R.C.P.,
Provincial Medical Director

June, 1951.

Articles

The General Practitioner and Civil Defence

J. N. Crawford, Colonel, R.C.A.M.C.

Directorate of Medical Services

A suitable text for the civil defence planner is found in Proverbs 29:18: "Where there is no vision, the people perish." The aim of all civil defence planning is to provide vision, so that the people will not perish.

At the outset, it should be made quite clear that by civil defence, we mean defence of civilians, by civilians. The armed forces should not be expected to play a leading role in civil defence. They will provide all possible assistance, but their primary task is to fight an enemy and defeat him in somebody else's country. This task may make it impractical to devote much of the strength of the armed forces to problems of civil defence in wartime. In other words, the enemy should not be able to pin large numbers of troops in Canada by the simple expedient of dropping a few bombs in Canadian territory, or by shelling a coastal Canadian city from a submarine. The Canadian civil defence organization should be capable of action quite independent of the armed forces. Any help which can be obtained from the armed forces should be looked upon in the nature of a bonus. However, unless at the time of a civil disaster the armed forces were actually engaged in fighting an enemy on Canadian territory, civil defence planners should reasonably expect considerable assistance from the armed forces such as, for example, a temporary supply of manpower and equipment, or temporary shelter for victims of disaster.

In these troubled times, when we think of civil disaster, we are likely to think of disasters which result from acts of war, and perhaps particularly of the tremendous disaster of an atomic bomb attack. There are, however, many civil disasters which have no relation to war. Within the past few months Canada has witnessed several of these, the result of fire and flood. Planning for civil defence, even though it be for the major disaster of an atomic explosion, is not wasted if no atomic attack occurs. The same plan can be applied in case of necessity, to any lesser but still serious disaster, in time of peace.

We will do well then to determine what sort of general organization, and particularly what sort of medical organization is necessary for civil defence in the event of an atomic explosion, knowing that

our planning, with modification, can be useful in event of lesser tragedies.

The Federal Government has suggested to Provincial and municipal governments an organization for civil defence¹, and it is felt that the outline presented can serve as a most useful basis for planning. Briefly, the plan envisages the organization of a civil defence zone around likely target areas. From this zone will come the manpower reserves required for assistance in a devastated city, and in it will be found the food and shelter required for casualties and evacuees.

The civil defence division, organized in a target area and defence zone, is broken down into:

1. Headquarters section for control, intelligence and communication.
2. Warden section, for warning and local control.
3. Rescue section.
4. Ambulance section, for transport of casualties.
5. Engineer section, for repair, maintenance, decontamination and heavy rescue.
6. Welfare section, for shelter, feeding, registration of evacuees, etc.

It is proposed that the full wartime establishment of such a division will utilize about 2% of the population in a target area. In peacetime this number is not required, but sufficient key personnel should be trained so that a rapid increase to wartime strength is possible.

The proposed civil defence division, although it allows personnel for the rescue and transport of casualties, makes no allowance for the treatment of casualties. No suggestion has been made for the organization of medical and nursing personnel, as it is considered that this can be done through the agency of district and provincial medical associations.

The purpose of this paper is to provide data which may be useful in planning a medical organization for civil defence.

The Magnitude of Effects of Atomic Explosion

In another paper² more detailed consideration is given to the effects of atomic explosion. It will be sufficient at this time to summarize these, basing the estimated effects upon the incident of an air burst of a nominal atomic bomb, exploded at about 2,000 feet above ground zero.

We can expect all buildings to be totally destroyed within a radius of $\frac{1}{2}$ mile, and very heavy structural damage will extend to $1\frac{1}{2}$ miles from ground zero. The effect upon existing hospitals in any city will depend upon the location of ground zero, but it must be expected that many hospitals will be destroyed or rendered useless. Streets will be choked with debris, and the rescue and trans-

1. Organization for Civil Defence, Manual No. 1, Ottawa, October, 1950.

2. Crawford, J. N., C.M.A.J., 62, 529-534, 1950.

port of casualties will be made very difficult. Fires will be raging within a radius of 2 miles. Radiation effects will be lethal to unprotected personnel within a radius of 1,300 yards, but will not interfere with rescue, as the radiation effect in an air burst is very brief. A median lethal dose of radiation is to be expected up to 1,500 yards from ground zero.

The ranks of the health professions, doctors, dentists, nurses, etc., will be depleted. The extent of this depletion will also depend upon the location of ground zero and the time of day at which the explosion occurs. In Japan 90% of doctors and nurses were unable to assist because of death or injury. With warning of attack, and with some knowledge of protection against this weapon, considerable improvement in this casualty rate is to be expected, but nevertheless fewer doctors will be available to help than are shown on the registration lists.

The number of casualties in need of assistance will be very large. In a city with a population density of 15 per acre the total living casualties may be expected to be from 20,000 to 40,000 depending upon whether or not the population has been able to seek shelter. Rescue operations will start at the periphery of the heavily damaged area. Within the first half mile, inward from this periphery, the living casualties will be 9,000 to 14,000. Another half mile of rescue operation can produce an additional 5 to 8,000 living casualties.

There should be no radiation injury within this first area of rescue operation. The injuries will be due to the secondary effects of blast (fracture, laceration, etc.) or to burns. 40% will be in need of good surgical care, and 10% of these will require urgent surgery. Within the second area of rescue operations, the picture will be complicated by radiation injury. Something in the order of 1,000 cases will have radiation injury, either alone or as a complication of other injury.

Role of the Medical Service

The task of the health service in the event of disaster is to provide treatment to the vast numbers of individuals who are injured. In order to do this they must take some interest in the problem of evacuation of casualties and in the provision of medical supplies. Inherent in the concept of treatment is the provision of reasonably adequate hospital facilities by the expansion of existing facilities and by the establishment and operation of emergency hospitals. Problems of public health are also a medical responsibility.

The health facilities which exist today in any target area are obviously inadequate to deal with a disaster of the magnitude described. They will require re-inforcement, in both personnel and supplies, from the facilities of the surrounding "cushion area" and the civil defence zone. In this

lies the importance of creating, in the minds of the medical practitioners in smaller non-target areas, an awareness of the role which they must be prepared to play. Those in cushion areas must plan to do two things:

1. Provide mobile re-inforcement to the target area.
2. Provide treatment facilities in the cushion area and the reception area.

The whole success of a civil defence plan will depend upon the acceptance and implementation of this concept of mutual aid. In many parts of Canada the arrangement will be reciprocal. If cities A and B are not far apart those in A must be prepared to take up the first shock of attack if A should be a target, and those in B must be prepared to assist from their vantage point in a cushion area. If B should be the target the roles will be reversed.

Medical Planning

In the Department of National Health and Welfare, at Ottawa, work is now progressing and is already far advanced toward the preparation of a manual for the guidance of the medical services in time of civilian disaster. This will be the Canadian counterpart of the U.S. Manual—"Health Services and Special Weapons Defense" with which you may already be familiar, but its approach will be modified to fit more closely the Canadian scene with respect to Canadian resources of medical manpower, Canadian geography, Canadian climate and so on. This manual will set out a plan of organization which it is believed should be followed in Canadian communities, and will provide figures and methods of planning which are essential in the preparation of a detailed defence plan. However, this manual, or any plans developed at the Federal level, can do no more than enunciate general principles of defence planning. The preparation of a detailed plan for any specific locality must remain the responsibility of local authorities, who are familiar not only with local resources, but with the capabilities and personalities of those chosen to play particular roles.

In a general way, any plan for health services in civil defence must take cognizance of the following:

1. The organization of an evacuation system from the site of the disaster to the first point at which any attempt at formal treatment can be made. Depending upon local circumstances this may or may not be entirely under medical control. It will generally be better to leave this link in the chain to rescue services, the members of which have been well trained in first aid.
2. The establishment and staffing of first aid stations as close to the site of disaster as possible. The number and location of these will depend upon the nature of the disaster, the shelter which is

necessary (depending upon climate) and the numbers of qualified people who are available to staff them. The American plan calls for 57 primary units of this nature, circling the site of disaster at a distance of 1½ miles, and 39 secondary units at a distance of 2 miles. The numbers of capable people in any Canadian city will not permit of such lavish distribution. Local facilities must dictate this distribution in any Canadian target. The type of treatment carried out at these stations will be chiefly that of arrest of hemorrhage, treatment of shock, immobilization of fractures and the dressing of wounds. A major function will be the triage of patients, and direction to hospitals or other shelters. However, under some circumstances, these stations may have to be expanded to play a "holding" role for a temporary period.

3. The organization of an evacuation system from these first aid stations to emergency or permanent hospitals in the cushion area or farther away in the defence zone, or to welfare areas in the defence zone.

4. The expansion of existing hospital facilities, and arrangements for re-inforcing the staff of these.

5. The establishment and staffing of emergency hospitals.

6. The demands of medical care in welfare areas.

7. The myriad problems of public health hygiene and sanitation imposed by a major disaster.

8. The stockpiling and delivery to the site of disaster of the astronomical quantities of medical supplies which will be required. These supplies must be available in moderate amount in or near a target area at the time of occurrence of a disaster. Regional stocks must be available so that the target area can be re-supplied within a matter of a few hours. As a result of Provincial-Federal discussion, agreement has been reached, or shortly will be reached, on the very important question of "Who pays for what?" but no amount of discussion is going to solve the very difficult problem of manufacture and supply in the required quantities. It is certain that all available supplies in commercial warehouses will have to be diverted to civil defence use when the occasion demands.

Pending the publication of these overall principles of planning, what steps should be taken by provincial and district medical associations? In the first place, local planning should be done from two points of view:

A. As a resident of a target area, who may be suddenly and intimately associated with a major civilian disaster.

B. As a resident of a cushion area, whose task will be to render assistance to the victims in a target area.

Some prediction of the probable role in individual cases can be made by utilizing information which has been made available to provincial cabinets. Likely target areas have been designated in each province. Some forecast of the most probable forms of attack, e.g., atomic, high explosive, incendiary, etc., has also been made. In those communities where a civil defence co-ordinator has been appointed medical planning will be done under his direction and will utilize the information which he can provide.

Secondly, a survey should be made of the local area, again considering it as a potential target and/or as a potential cushion. The information to be provided is:

1. Population density by day and by night, in various parts of the city. This information is essential in estimating casualties.

2. Existing hospital facilities. Due allowance must be made for the destruction of part or all of these. What expansion of these can be provided by utilizing such space as corridors, conference rooms and so on; by limiting admission to emergency cases; by discharging those capable of being treated under the more or less makeshift arrangements of a welfare shelter area?

3. Selection of sites for possible emergency hospitals. Attention must be given to facilities of water supply, heating, power, sewage, and evacuation of patients by road, rail or air.

4. Available personnel, including doctors, dentists, nurses, pharmacists, nurses aides, etc., in both target and cushion areas. Some tentative planning should also be done toward assignment to specific duty in the civil defence front. It must not be forgotten that many of these helpers will not be available because of commitment with the Armed Forces, and others may themselves be the victims of disaster.

5. Vehicles for conversion into temporary ambulances.

6. Medical supplies, including stocks in hospitals, supply houses and commercial warehouses in the area.

Thirdly, the medical profession and the allied health professions must organize themselves to meet the demands which may be made upon them. The first step in medical planning should be taken by the medical director who will work both in the planning stages and in the event of disaster under the guidance of the controller of civil defence. Plans must be made for assignment to specific duties in the event of disaster, this assignment being sufficiently flexible to deal with a considerable number of variables brought about by shifts in ground zero, changes in location of aid stations and emergency hospitals, and so on. The profession must be prepared to submit to a course of study concerning the problems to be met, and

utilizing sand table demonstrations and actual tactical schemes.

This paper has attempted to point out, as briefly as possible, some of the problems facing the health professions in the event of civilian disaster, and to outline the principles which may be followed in planning to meet them. It has not taken into consideration the problems imposed by chemical or bacterial warfare. These will be dealt with elsewhere, and at least carry some consolation in that they will not likely be accompanied by widespread destruction of facilities.

The problems are great. With the best planning and the best facilities, some must still perish as a result of an enemy aerial attack, but thought and planning will save many. These can fight on, until the day when real peace will permit us to relax our vigilance.



Concerning Autopsies*

The Object and Scope of the Autopsy

Autopsies are scientific procedures, the purpose of which is to establish with all possible accuracy the cause of death; to determine the nature and cause of the pathological processes involved, and to acquire reliable information concerning the nature and cause of disease. The ultimate objective is to add to the sum total of our knowledge concerning the diseases from which the patient suffered and in this way to improve the health of mankind.

The percentage of autopsies is one of the best indices of the standard of medical practice in an institution. For this reason the American Medical Association requires as a criterion for approval of hospitals the maintenance of a satisfactory autopsy percentage.

Obtaining Consent for Autopsy

Consent for autopsy must be obtained from the person who is the legal custodian of the body and responsible for its proper disposal. The right to grant permission for autopsy rests with the husband, wife, or next of kin.

When there is a controversy among members of a group of equal kinship over giving permission for autopsy, it is unwise to accept consent from one while opposition exists among the others.

Technic of Obtaining Consent for Autopsy

The first requirement for obtaining consent for autopsy is that every member of the hospital organization realize the value and the importance of postmortem examinations.

This activity cannot be left to chance or to inexperienced persons. Success in obtaining con-

sents for autopsies can be achieved only by the co-operative effort of the administrative, medical and nursing staffs of each hospital. This effort must be carefully planned and persistently followed. No approach can be successful without the prior goodwill of the bereaved family. No opportunity must be overlooked to convince the patient while alive of the concern of the hospital for his welfare. When a patient becomes critically ill, the family should be notified promptly. After death the bereaved should be treated with sympathy and tact. Any act that might be interpreted as one of neglect or disrespect, even though unintentional, will stiffen their resistance and reduce the likelihood of obtaining consent.

Whatever arguments are advanced should be truthful and tactfully presented. What is not stated with sincere conviction cannot be convincing to the relatives.

The following is a sample of arguments that may be advanced and objections that should be anticipated:

Arguments

1. The autopsy is the most accurate means of determining the cause and mechanism of death; it often reveals quite unexpected findings.

2. Familial diseases may be exposed for the benefit of survivors.

3. The dependable vital statistics that result from accurate certifications are of immense importance to humanity.

4. Medical knowledge and research are advanced.

5. The medical education of the hospital staff is fostered, thus increasing efficiency locally in the care of the sick.

6. Information can be obtained that is of importance in litigation re pensions.

7. Public safety is promoted by the detection of unsuspected criminal acts.

8. Families derive comfort from the dispelling of uncertainty in deaths that are clinically of obscure cause.

9. Opposition to autopsy means opposition, though unwitting, to improving the health of human beings.

10. "Mortui vivos docent" (The dead teach the living). Thus, the last gesture of the deceased is in the direction of aiding and co-operating with the living.

Objections to Autopsy

Objection—"The deceased will be disfigured or even mutilated."

Answer—The incision does not show above the clothing. It will be skillfully made by an experienced autopsy surgeon and is in many respects comparable to an operative incision; the vessels

*From a little booklet prepared by a joint committee of pathologists, hospitals and funeral director of New York City. Prepared by T. H. Williams, M.D., C.M., D.T.M. & H., F.C.A.P., Chief of Laboratory Services, Deer Lodge Hospital.

will be ligated and the embalmer aided in his task. No competent pathologist countenances mutilation.

Objection—"The deceased has suffered enough."

Answer—The dead body experiences no pain. Incisions and punctures have to be made at times in the course of embalming. Certain unintelligent persons and families have been known to object to life-saving surgery. The unreasonableness of such objections has now been generally recognized. Ultimately, objections to properly conducted autopsies will probably fall into the same disrepute.

Objection—"Let someone else be the one to be experimented upon, not our relative."

Answer—If everyone adopted this selfish attitude there would be very little medical progress. In answering this objection it is important that evidence be presented to show that medical men encourage autopsies when deaths occur in their own families. Names of prominent persons who requested autopsy after death, or whose families have requested it, should be cited as illustrations of the example to follow.

Objection—"The deceased would not have wanted, or had expressed objection to an autopsy."

Answer—It is difficult to be objective about oneself. Persons who are ill have an altered mental outlook toward death. If the individual had been in complete control of his faculties his desire would probably have been the generous and unselfish one of helping others after he himself was beyond medical aid.

Objection—"This condition from which the subject died is not an unusual one and is well understood."

Answer—It so often occurs that at autopsy medical information is obtained which before was unknown or unsuspected that routine autopsies are accepted as desirable, just as during life certain routine tests are made for the important information they give that would otherwise not be available.

Objection—"There are religious objections to autopsy."

Answer—This statement is untrue. There are on record authoritative statements from religious leaders of all faiths indicating that nowhere is there any justification for opposition to autopsies on religious grounds. The enlisting of co-operation on the part of the hospital chaplain will often help in overcoming this type of opposition.

When Consent for Autopsy Has Been Obtained

When consent for autopsy has been obtained, the postmortem examination should proceed without delay. If the family or the funeral director has specified that the body is to be released by a certain time, every attempt should be made to comply with their wishes. Restrictions imposed by the family with regard to the extent of the autopsy must be respected by the person who performs it.

In the zeal to obtain permission for autopsy, no one should make any promises which cannot or will not be kept. If, in order to obtain consent, limitations are accepted, these must be strictly adhered to. To do otherwise is inexcusable, constitutes a betrayal of the family's confidence, and may lead to a law suit. As a general rule it will be found that unreasonable restrictions need not be promised. The relative who will give consent for autopsy will usually permit an extent of post-mortem examination that will give adequate information.

Whenever an extensive dissection is necessary, every effort should be made to co-operate with the embalmer in proper restoration of the body before its delivery. At the conclusion of the autopsy a responsible member of the pathology department should review the body to check the condition in which it is delivered to the funeral director.

Coroner's Cases

The following cases are required by law to be promptly reported by the hospital authorities to the office of the coroner.

1. Deaths by homicide or suspicion of homicide including technical automobile homicides and cases of criminal negligence.
2. Deaths by suicide or suspicion of suicide.
3. Deaths due wholly or in part to accidental injuries including industrial accidents.
4. Deaths by abortion except therapeutic abortion.
5. Deaths by poison or suspicion of poison including chemical and bacterial food poisoning and industrial poisoning.
6. Deaths in any unusual, peculiar, or suspicious manner or unattended by a physician or in coma or convulsive seizure, the cause of which is not apparent.

Care of the Body after Death

For the embalmer to obtain the cosmetic results that are expected of him, the nursing staff should be thoroughly instructed in the following principles of care of the body after death has been pronounced.

1. The head and shoulders should be elevated.
2. Bandages, if applied to the face, should be applied gently with padding and a wide bandage.
3. The hands should be laid at rest on a higher level, as on the chest. Support by a wide bandage above the elbows.
Never tie at wrists.
4. At no time while in transit from the hospital room to the mortuary should the body be unattended or left where unauthorized persons may have access to it.
5. The body should never be left in a heated room, and wherever possible, it should be kept in

a properly refrigerated compartment with head and shoulders elevated.

6. There should not be packing of eyes, nose or mouth.

7. All clothing should be removed and the body covered with a sheet.

Recommended Autopsy Room Procedure

1. Autopsies are important and desirable and must be performed properly and promptly in order not to inconvenience either the family of the deceased or the funeral director. Prompt delivery of the body should be arranged for at the appointed hour. If delay is anticipated, the funeral director should be notified by telephone in advance. The pathologist should not incise exposed parts of the body and whenever possible should avoid destroying vessels needed for embalming.

2. The initial autopsy incision is of the "cross-bow" or the Y-type; it extends between the anterior axillary folds and in the case of women always below the breasts, which when pendulous can be retracted upwards. This incision is joined by another in the midline extending downward to the pubis, passing to the left of the umbilicus. In dissecting the upper flap free from the deeper structures, care must be taken to avoid perforating the skin, especially over the manubrium.

3. Embalming of autopsied bodies is carried out through the common Carotids, subclavian and iliac arteries. It is therefore important that those vessels be left intact. Whenever possible, the pathologist should leave the upper rim of the aortic arch in place, with the great vessels attached; otherwise a string or tape should be tied loosely to the lower ends of the great vessels, to make these vessels readily available. The distal segment of the external iliac arteries should also be left intact. When possible, the iliac vessels should be left attached to the lower-most portion of the aorta.

4. Incisions in the scalp are a source of concern to the funeral director, especially when the subject is bald. For effective concealment, the ends of the scalp incision should be located just behind the ears, never above or in front of them; it is extended up on each side crossing the top of the scalp a little behind the vertex. Care should be taken not to destroy any hair.

The scalp is dissected loose and reflected backward and forward, care being taken not to "button-hole" the forehead. The flaps are easier to reflect if the skin behind and above each ear is under-cut and dissected loose from underlying structures.

Before removing the calvarium, the proposed saw cuts should be outlined with a sharp instrument in two planes intersecting at an obtuse angle on the lower lateral portions of the skull. The anterior saw cut should be located just behind the normal hair line. If this is not done, the location

of the sawed edges may show through the skin. The posterior saw cut should be curved inward at the midline, thus making it possible for the embalmer to anchor the skull cap. The posterior saw cut passes through a point just above the apex of the lambdoidal suture. Care should be taken not to soil the hair with blood.

6. Following autopsy the body cavities are cleaned out and wiped dry. Viscera returned to the body should be drained of excess fluid and fecal matter. Only the pelvic cavity need be packed with cotton or other absorbent material, to prevent leakage, as the embalmer opens all incisions and empties the body cavities, temporarily, in preparation for embalming.

7. All incisions should be sewn with cotton cord, using an ordinary "baseball" stitch.

The body should be washed thoroughly and dried before being wrapped in the shroud.

American Medical Association Meeting

Reported by L. A. Sigurdson, M.D.

The American Medical Association held their one hundredth annual scientific assembly in Atlantic City, June 11-15, 1951. About 28,000 registered for the meeting. These included 12,000 doctors, 16,000 guests, amongst which were internes, resident physicians, nurses, technicians and others connected with the profession.

The retiring president, Elmer L. Henderson, announced that the campaign to combat compulsory health insurance was over because the efforts to socialize medicine have been defeated. Dr. John W. Cline of San Francisco, was installed as the new president of the American Medical Association. He stated that the United States was the healthiest nation in the world. He went on to say that:

"Since the turn of the century almost 20 years have been added to the life span of the American people. The general death rate during the same period has been cut almost in half. This represents the saving of more than one million American lives every year."

"I believe the mothers of America will consider that these achievements far outweigh the empty promises of those who urge a system of government-controlled medical care. We cannot afford to sacrifice this record upon the altar of a socialistic experiment."

Section on General Practice

Dr. Lester D. Bibler, of Indianapolis, was the chairman of the section. In his opening remarks he stated that the family doctor is on the rebound. Overshadowed in an age that saw physicians follow the trend to specialize, the pendulum is swinging back to the general practitioner so popular in the horse-and-buggy days.

Among some of the papers read were: Operation for Coronary Artery Disease; The Responsibility of the Physician to His Patient; The General Practitioners' Role in the Management of Personality Problems of the Adolescent; Diagnosis of Pathology of the Uterine Canal with the Lens Hysteroscope; Obstetric Hemorrhage and the Fatal Pause in the Diagnosis of Neoplastic Disease in the Physician's Patient."

The last paper revealed that in a study of 1,000 cases of physicians admitted to hospital, 68 cancer cases were found and the startling fact emerged that from the time of the initial symptoms to the beginning of treatment a much greater amount of valuable time was lost in this group than in the general population suffering from the same disease.

Section on Internal Medical

"Needless Restriction Imposed on Cardiac Patients" was the subject of an interesting paper read before this section. The conclusions reached were that many of the restrictions were too rigid and unjustified. Many of the restrictions are placed on the patient by the physician who wishes to avoid criticism in those cases that have an unfavorable outcome.

Section on Surgery

Chairman of the meeting was Dr. I. S. Ravdin, of Philadelphia. In his opening address he urged the doctors to "Clean House" by adopting policies

aimed at curbing unethical medical practices; such as excessive surgical fees, elimination of needless operations which cater to the whims of distraught patients, and calling in of consultants where these were not necessary.

Section on Obstetrics and Gynecology

The chairman of the meeting was Dr. Arthur B. Hunt from Rochester, Minn. Amongst some of the papers read before this section were: The use of Intravenous Iron in Obstetrics and Gynecology, Management of Pregnancy in the Diabetic Patient, The Effects of Sheep Gonadotropins on the Human Ovary, Frigidity in Women, Cytology for Early Detection of Uterine Cancer, The Duration of Pregnancy and Postmaturity. In reference to the last paper, Dr. H. L. Stewart of Detroit, Mich., stated: "There is no evidence supporting alleged postmaturity of 10 to 11 months."

Television

Presented from Atlantic City Hospital, Atlantic City, N.J., under the sponsorship of Smith, Kline and French Laboratories. Eighteen receiving sets were arranged in the big hall so that 900 people could watch color television of various operations including Cholecystectomy, Nephrectomy, Appendectomy, Hysterectomy, and Cæsarian section. On Thursday afternoon a normal delivery was televised before 1,500 people. The baby weighed 9 pounds 12 ounces.

Manitoba Medical Service Memos Trans-Canada Medical Services

Background

A subcommittee, appointed by the Conference of Canadian Prepaid Medical Care Plans in November, 1949, and reappointed in June, 1950, met in Toronto on May 3rd, 1951. All three members were present—Dr. H. D. Logan, Physicians' Services Incorporated; Dr. F. A. Brockenshire, Windsor Medical Services Incorporated, and Dr. J. C. MacMaster, Manitoba Medical Service.

The report of the subcommittee was distributed to the plans from the central office of the Canadian Medical Association, and representatives of the Provincial Plans met at the Mount Royal Hotel, Montreal, from June 16th-19th, 1951, with Dr. C. C. White of Chatham, Ontario, as Chairman, to receive the report and consider it section by section.

With modifications the report was adopted and Trans-Canada Medical Services was established by assent of the founder plans viz:

Maritime Medical Care Inc.—Halifax, Nova Scotia.
Physicians' Services Inc.—Toronto, Ont.
Manitoba Medical Service—Winnipeg, Man.
Medical Services Saskatoon Inc.—Saskatoon, Sask.
Group Medical Services—Regina, Sask.

Medical Services (Alberta) Inc.—Edmonton, Alta.
Medical Services Association—Vancouver, B.C.

Aims and Objects

Primarily the objects of Trans-Canada Medical Services are to promote the establishment and operation of such non-profit, voluntary medical care plans throughout Canada as will adequately meet the health needs of the public and maintain the high quality of medical care rendered by the medical profession. Inherent in these objects is a recognition that provincial plans should be autonomous in their operation so that the needs, facilities, resources and practices of their respective areas can be given due consideration, but that the health and welfare of the public may be advanced by the co-ordination, through the medium of this organization, of methods, coverages, operation and actuarial data.

Organization

A corporate structure was deemed undesirable. An informal association of the plans was favoured. A Commission derived from the plans would act as agents in respect of specific activities.

a. Commission composed of one representative from each medical plan having the endorsement of the Division of the Canadian Medical Association in that Province, together with the Chairman of

Economics of the Canadian Medical Association. Dr. P. H. McNulty, of the Manitoba Medical Service, was elected as Chairman of the Commission.

b. Executive Committee — Chairman of the Commission, Dr. P. H. McNulty; Vice-Chairman, Dr. H. D. Logan, P.S.I., Toronto; Hon. Secretary, Dr. N. H. Gosse, M.M.C.I., Halifax; Hon. Treasurer, Dr. McCoy, M.S.A., Vancouver.

Finance

The suggestion to set up an office in Eastern Canada with an Administrator in charge was opposed on several grounds by M.M.S. and this attitude was supported by several plans. The Commission preferred to move carefully ahead dependent on the spare time activities of Administrators and activities of the Executive Committee. There would be an initial small levy on the plans to meet the cost of supplies, printing, etc.

Activities

The Commission suggested that the Administrators might organize themselves at a private meeting, and invited the Committee, if so formed, to co-operate towards realizing the aims and objects of the T.C.M.S. Dr. McNulty, Chairman of the Commission, briefly addressed the administrators on the morning of June 19th, 1951, at the opening of their session and asked that recommendations from their initial and subsequent studies be made to the Commission. The Committee of Administrators undertook to address itself to the following projects and assignments were accepted by the Plan Directors. Reports will be collected and edited by Dr. MacMaster of the Manitoba Medical Service for referral to the Commission.

Assignments

Preparation of Brochure—M.M.S., Winnipeg.

1. To interpret the national scope and significance of the non-profit medical care plan movement under medical society auspices.

2. To engage the interest of large enterprises or governmental or national agencies such as associations, welfare or industrial groups.

Preparation of Manual for inter-plan administrative reference—M.M.S., Winnipeg.

Drafting of reciprocity arrangements—M.S.A., Vancouver.

Provision of coverage on transfer of residence—M.S.S.I., Saskatoon.

Drafting of a medical contract suitable for Dominion wide use—G.M.S., Regina.

Non-group enrollment—P.S.I., Toronto.

Community and Rural enrollment—M.S.S.I., Saskatoon.

Coverage for dependents of personnel in the Defence Services—M.M.C., Halifax.

Coverage for pensioners, indigents and those in the social welfare category—P.S.I., Toronto.

Contracts for employees of national employers—G.M.S., Regina.

Finance Budgets—M.S.A., Vancouver.

Research and compilation of statistics—financial and service data—M.S.A., Vancouver.

Public relations—M.M.C., Halifax.

Professional relations—M.S.A., Vancouver.

Relations with Blue Shield (National Associations of Medical Care Plans, U.S.A.)—P.S.I., Toronto.

Relations with other agencies in the medical care field—M.S.A., Vancouver.

Dr. J. C. MacMaster,
Executive Director,
Manitoba Medical Service.

Enrollment Report, June, 1951 Progress

Enrolled on group reopenings and by new groups, 1,870.

New Groups for June, 1951

Dauphin Broadcasting Company, Brandon College, Canadian Salt Company, Neepawa, Treherne Community Group, No. 1 Waskada Community Group, No. 2 Waskada Community Group, City of Winnipeg, Pensioners, Canadian Industries Limited, C. R. News, Aero Caterers, Ancient Order of United Workmen, Bell Bottling Company Ltd., Buffalo Cap, Commonwealth Construction Company, Fredericks Limited, General Acc. Fire, Life Assurance Company, National Cloak Company, A. W. Pigott Limited, Seiberling Rubber Company, S. & S. Sportswear, Bile & Sons Leather Goods, C.P. Officers, Lithographers Association, Electrical Supply Limited, Gillis & Warren Limited, Martin Paper Products, Casualty Insurance Adjusters, Retail Clerks, Safeway Managers.

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—P. BROWNELL, Reg. N., Director.	

Medico-Historical



Months and Caesars

July, originally the fifth month of the Roman calendar and then called Quintilis, has varied in the number of its days. At first this was thirty-six. Romulus reduced it to thirty-one and Numa removed another day. As this was his natal month Julius Caesar felt a personal interest in it and lengthened it to thirty-one days. After the death of the great reformer of the calendar, Mark Antony changed its name to July in honour of Caesar's family name. Moreover in this month the sun is most potent and the change of name most effectively denotes that Julius was the emperor of the world and therefore the appropriate leader of one-half of the year.

We remember the great Julius chiefly as a general and as the author of those Commentaries which it was our boyhood task to translate. In a more professional way we may recall him as an epileptic and as a sufferer from malaria. But our interest in him should be deepened by the recollection of his consideration for the doctors of his time.

Then doctors were for the most part Greek slaves. Learning and culture of any sort were frowned upon by those to whom the supreme goods were power and wealth. Learning was for slaves and no dignity attached to physic. Every Roman was his own doctor and the doctor likewise of his dependents. Medicine was every man's business which explains why so many Latin authors abound in medical advice. There was, to be sure, no lack of treatment but the Romans were "sans médecins mais non sans médecine" until the Greeks brought it as the talent of slaves.

Of all slaves doctors were the most valuable. They were more expensive even than eunuchs—a thought that must have brought some comfort to our degraded fore-runners. Rich Romans bought them for domestic use or farmed them out or sold their services acquiring in the process great wealth and other advantages. There was a ready market for these medici some of whom were general practitioners, others specialists; some honourable and others out-and-out murderers ready, able and willing to misguide the lance or to prepare a poisoned chalice.

Not all physicians were slaves. Some were adventurers careless of how they became rich. Some had never sworn or had forsworn the ancient oath. Most of them, easily or reluctantly, fell prey to the prevailing cupidity, and battened richly on the credulity or depravity of the masters of the world.

Unlike most of his patrician contemporaries and predecessors Caesar had a knowledge of Greek and respect for the Greeks. His earliest literary

efforts include "The Praises of Hercules" and "The Tragedy of Oedipus." Perhaps he had sympathy for, and understanding of the Greek medici. Perhaps he realized that slavery begets corruption and that nowhere is corruption more vicious than in physic. For either or both of these reasons he freed the doctors from their slavery, and it was not until the physicians were admitted to the enjoyment of all the rights and privileges of Roman Citizens that medicine grew in Rome.

Julius was followed by Augustus and what Mark Antony did for his predecessor Augustus did for himself—he gave his name to a month. Moreover, that he might no more take second place to Julius he added an extra day (taken from February) to his month in which also the sun was potent. He chose Sextilis for this honour not because he was born therein but because in it had happened a number of fortunate experiences.

Augustus died (in the month to which he gave his name) from "a sickness he caught by a flux of the belly." He died "an easy death and such as he had ever wished to have. For usually, so often as he heard of anybody to have departed this life quickly and without pangs, he prayed to God that he and his might have like euthanasia for this was the very word he was wont to use."

So wrote the author of "The History of the Twelve Caesars" and Suetonius tells us other things about Augustus that are not without interest.

"His body, by reports, was full of spots, having upon the breast and belly natural marks which he brought with him into the world, dispersed, for the manner, order, and number, like unto the stars of the celestial bear; as also certain hard risings of thick brawny skin, occasioned in divers places by the itching of his body, and the continual and forcible use of the strigil in the baines; which callosities resembled a ringworm. In his left huckle-bone, thigh and leg, he was not very sound, insomuch as many times for grief thereof he halted on that side; but by a remedy that he had of sand and reeds he found ease and went upright again. Also, the forefinger of his right hand he perceived otherwhiles to be so weak that, being benumb and shrunk by a cramp upon some cold, he could hardly set it to any writing, with the help of a hoop and finger-stall of horn. He complained also of the grief in his bladder, but voiding at length little gravel-stones by urine, he was eased of that pain.

All his lifetime he tasted of certain grievous and dangerous sicknesses, but especially after the subduing of Cantabria; what time, by reason of his liver diseased and corrupted by distillations, he was driven to some extremity, and thereby of

necessity entered into a contrary and desperate course of physic; for, seeing that hot fomentations did him no good, forced he was, by the direction and counsel of Antonius Musa, his physician, to be cured by cold. He had the experience also of some maladies which came yearly and kept their course at a certain time. For about his birthday, most commonly he was sickish and had a faintness upon him; likewise in the beginning of the spring, much troubled he was with the inflation of the midriff and hypochondrial parts; and whensoever the wind was southerly, with the murr and the pose. By occasion whereof, his body being so shaken and crasie he could not well endure either cold or heat.

In winter-time clad he went against the cold with four coats, together with a good thick gown, and his waistcoat or petticoat body of woollen, well-lapped also about the thighs and legs. During summer he lay with his bed-chamber doors open, and oftentimes within a cloister supported with pillars, having water waling out of a spring, or running from a spout in a conduit, or else some one to make wind hard by him. He could not

away so much as with the winter sunshine; and therefore, even at home, he never walked up and down in the air without a broad-brimmed hat upon his head. He travelled in a litter, and never lightly but in the night. The journeys that he made were soft and small, so as if he went from Rome but to Tibur or Praeneste, he would make two days of it. Could he reach to any place by sea, he chose rather to sail thither than go by land. But as great infirmities as he was subject unto, he maintained and defended his body with as much care and regard of himself, but principally by seldom bathing; for anointed he was very often and used to sweat before a light fire, and then upon it to be doused in water lukewarm, or else heated with long standing in the sun. And so often as he was to use the sea-waters hot, or those of Albula for the strengthening of his sinews, he contented himself with this, namely, to sit in a wooden bathing-tub, which himself by a Spanish name called dureta, and therein to shake up and down his hands and feet, one after another by turns."

Coming Events

International College of Surgeons

The sixteenth annual assembly of the United States Chapter of the International College of Surgeons will be held in Chicago on Sept. 10th through the 13th, 1951, with headquarters at the Palmer House.

An excellent programme has been arranged. Prominent surgeons from the United States and other countries will participate. Scientific sessions will be held by all specialty sections of the United States Chapter.

The annual banquet will take place on Wednesday evening, Sept. 12. Mr. Lawrence Abel, F.R.C.S. (Eng.), of London, will be the principal speaker.

The assembly will conclude with the convocation, to be held in the Civic Opera House on the evening of Sept. 13. Senator Estes Kefauver will deliver an address on "The America of Tomorrow."

Hotel reservations may be arranged by writing to the Housing Division, Chicago Convention Bureau, 33 North LaSalle Street, Chicago 2, Illinois.

Course in Postgraduate Gastroenterology

The National Gastroenterological Association announces that its course in Postgraduate Gastroenterology will be given at the Drake in Chicago, Illinois, on Sept. 20, 21, 22, 1951.

This year the course will again be under the direction and co-chairmanship of Dr. Owen H. Wangenstein, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education of The Mt. Sinai Hospital, New York, N.Y., who will serve as medical co-ordinator.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, New York.

Arthritis Awards Announced

Awards totalling \$81,000 have recently been made by the Canadian Arthritis and Rheumatism Society for Clinical Fellowships and Research Fellowships and Grants. Several Manitoba doctors are amongst the recipients, including Dr. Metro Ogryzlo and Dr. John Hughes.

The provision of these fellowships is part of the Society's national effort to further research into the cause and treatment of rheumatic diseases and to aid general professional knowledge.

Manitoba Medical Association—Annual Meeting, Fort Garry Hotel, Winnipeg, Man., October 9th, 10th, 11th and 12th.

Book Reviews

The Index of Modern Remedies

The *Index of Modern Remedies* published by the Scottish Chemist appears in its first North American Edition. The publishers say of it "In the compilation of this publication an effort has been made to place before the profession a concise listing of ethical products available in the United States, Canada and Great Britain."

The 166 pages are divided into two sections—North American and British. The remedies are grouped according to actions and the actions are listed alphabetically—Anaesthetics, Analgesics, etc. The following is an example of the manner of description "Alkagen, antacid granules containing magnesium hydroxide with glucose and peppermint supplied in 4 ounce bottles (AH)." The initials in brackets are those of the manufacturer and a list of the abbreviations precedes the descriptions.

The British Section opens with lists of the admissions, deletions and changes appearing in the B.P. of 1948 and with changes in the B.P. codex of 1948 and in the National Formulary of 1949. In addition there are useful tables of data regarding the sulphonamides and barbiturates.

This little book will prove useful to those who wish to have at hand a convenient list of "ethical" remedies. It contains a lot of information not easily found elsewhere.

The Scottish Chemist's *Index of Modern Remedies*. First North American Edition, Canadian Address Box 275, Terminal "A" Toronto, Ont. Price \$2.00.

Multum in Parvo

For leisurely reading one prefers large books which go into matters deeply, but when one seeks the essence of a subject he turns to a small book in which case he desires a volume that is not only authoritative but completely up to date.

The handiest guide to speedy establishment of proper procedure is now in its second edition. Entitled "*Handbook of Medical Management*" it exceeds its title in that there is much added of diagnostic nature. So far as its scope is concerned it includes all the established advances of the past year. Moreover it includes B.P. remedies.

The arrangement remains unchanged. There is first a chapter on the General Aspects of Medical Care which is comprehensive enough to include such matters as "Measures for reducing the hazards of complete bed rest." The section on "Fluid and Electrolyte Therapy and Parenteral Treatment" is complete with tables; indications for this measure or that; comparison of metabolic and respiratory alkalosis and acidosis; diagrammatic correlation of potassium concentration and E.C.G. changes, etc.

Similar thoroughness is found in every chapter.

Following the two introductory chapters there is one on General Symptomatic Treatment and another (very full) on Dietetics and Nutrition. Then come fifteen chapters devoted to the disorders of as many systems. In each case there are diagnostic notes and considerations of laboratory and mechanical findings.

Treatment is divided into Specific, General and Symptomatic. When the specific remedy is a new drug careful instructions are given as to indications, contra-indications, dosage, etc.

A chapter is given to Hormones and Hormone-like Agents. Here ACTH and Cortisone are included. Another chapter deals with the symptoms and treatment of poisoning. There is a full index and also an ingenious method for leading the reader quickly to any particular section.

There is an amazing amount of information packed into 508 pages. Terse, systematic instruction, simple expression, the use of an abundance of charts, tables and diagrams makes for short reading time, clear understanding and quick comprehension.

The book fits a pocket snugly. It can easily be carried and should prove to be a useful vade mecum for students, especially for internes. Those practitioners who are familiar with the earlier edition will want this latest one, and new purchasers will quickly appreciate its daily usefulness.

Handbook of Medical Management, by M. Chatton, S. Margen and H. Brainerd. 508 pages with over 100 charts, tables, diagrams and illustrations. University Medical Publishers, P.O. Box 761, Palo Alto, California. \$3.00.

Patterns of Disease

Text books on pathology tend to emphasize (if they do not confine themselves to) structural change; for in none do disturbances of function get equal recognition. Yet, from the clinical standpoint, morbid physiology is of greater importance than morbid anatomy for it is abnormal physiological activity that is responsible for the symptoms we seek to explain.

Moreover, the body which has become the seat of disease is like a state which has been invaded by an enemy. In both there are first passive changes and then reactive processes which are not only local but general also. The student and practitioner must be familiar with the gross and microscopic appearance of disorganized structures and they must know what is known about the genesis and course of morbid processes; but, after all, the important questions concern function—how it has become changed and how nature is compensating for disorder or destruction. An

understanding of these factors leads to a better comprehension of the ailment and a more rational approach in treatment.

In his "Patterns of Disease on a Basis of Pathologic Physiology" Apperly seeks to follow the morbid process from its biochemical or functional genesis to its structural end. Further, he lays stress upon the compensatory mechanisms of the body, mechanisms which may ultimately affect many organs and structures in many systems. These are the processes which produce symptoms and which, when successful, lead to recovery with or without resultant structural deformity.

Thus Apperly brings pathology to the bedside in, as it were, an active form. The student and attendant as well are encouraged to see within the patient before them a living process rather than a conjured-up "specimen" from the dead-house. "Patterns of Disease" lays its emphasis on the activities that make possible the continuation of life rather than upon the processes that lead to death; yet these also are clarified for, just as structure without function is meaningless, so a knowledge of functional disturbance gives greater significance to structural change.

The book is divided into twenty-seven chapters. The first is entitled "Life and Disease"; the last, "Disease and the Man." These titles show how radical is Apperly's departure from the usual text on pathology. The emphasis is laid upon man himself as an active participant in his ailments, not upon a structural lesion for which the patient

is a necessary but otherwise negligible vehicle. Moreover the intangible mind is brought into the pathologists's ambit; and not only does he consider the pathogenic influence of psyche over soma, but (though much less fully than he might) with the psychic effects of somatic disturbance.

Between the first and final chapters are twenty-three others of which thirteen deal with the diseases of as many systems. The other chapters include two on the Passive Changes in Disease (cellular nutrition and its disturbances, and disturbances of peripheral circulation), three on Reactive Changes to Injury (local and general reactions), and others on Infection and Resistance; Special Types of Inflammation; Pigmentation and Degeneration; Hypertrophy and Hyperplasia; Tumors and Cysts.

The material is based upon the author's lectures on pathology in the Medical College of Virginia but this does not mean that only undergraduate students will find the book of profit. It is necessary for practitioners to reacquire themselves from time to time with those sciences which, because they are basic, must be kept in mind. Apperly's method of approach is likely to attract men in practice to refresh their knowledge of pathology. Easy reading, clarity of expression and clinical applications will make the book a favorite.

Patterns of Disease on a Basis of Physiologic Pathology, Frank L. Apperly, M.A., M.D. (Oxford), D.Sc., F.R.C.P. (London), Professor of Pathology, Medical College of Victoria. J. B. Lippincott, Montreal, \$9.50.

Biographical Sketch of Dr. H. S. Sharpe, Brandon, Man.

Upon Whom Senior Membership Was Bestowed at Recent Canadian Medical Association Meeting

In 1905 he graduated from Medical Faculty in the University of Manitoba with the degrees of M.D., C.M.

Began private practice in Langdon, Alberta, and continued there until 1906. Moved to Gainsboro, Sask., in 1906, and remained there until 1909. Then took up private practice in the City of Brandon. In 1915, with Dr. W. A. Bigelow and the late Dr. L. J. Carter, founded the Bigelow Clinic, this Clinic being the first formed in Canada. The Clinic was augmented after four or five years by the addition of Dr. S. J. S. Peirce and Dr. R. P.

Cromarty, and again during the last five years by the addition of Dr. Victor J. H. Sharpe and Dr. Dan R. Bigelow.

In 1922 was admitted as a Fellow of the American College of Surgeons.

Certified in Orthopaedic Surgery by the Royal College of Physicians and Surgeons of Canada.

Charter Member of the Canadian Orthopaedic Association.

Lecturer in the Brandon General Hospital School of Nursing on Paediatrics, Dietetics, and Orthopaedic Nursing.

Since 1917 identified with the St. John Ambulance Association as Lecturer and Examiner and Divisional Surgeon of the Nursing Brigade in Brandon Centre.

Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

The Convention

Elsewhere you will find the Convention Programme as it stands now. It is as well balanced as time and circumstances would permit. There is enough variety to make attendance worth your while. Moreover you will have the opportunity of hearing visiting, as well as local authorities.

Special mention must be made of Professor Wintrobe. As you already know he is one of our Alumni and, as such, gives lustre to our College. His reputation is great and established. His engagements are many. Yet when asked to speak to us he put himself to great pains in order to oblige us. He has a speaking engagement in Washington, D.C. but has arranged it that he will leave that city on Wednesday evening and be here early Thursday. It is good of him to go to this trouble for us.

Dr. Walkin who used to practice on Ashern's icy (and impecunious) plains, but forsook them for California's coral (and golden) strands, was in town recently and expressed the intention of persuading the many Manitobans he knew to come north with him. I imagine most expatriates wish now and then to revisit their original habitat and Convention Week seems an ideal time for reunions. We hope that very many ex-Manitobans will find their way here in October. And we hope that they will bring friends with them.

Purely Personal

I feel that an apology is coming to those who received the June-July number. Not until I saw my own copy did I realize that I had been the victim of a conspiracy. The book falls open naturally in such a way as to expose the two innermost pages. Under ordinary circumstances the reader's eyes then fall upon information about Messrs Ayerst, McKenna and Harrison's excellent products. But in the number to which I refer the view was more disturbing. On one side was, an unflattering (but I am told, a truthful) portrait of myself and, on the opposite page, a flattering but questionable truthful eulogy. As this was couched in the past tense, all it required was a black edging to make it an elegy; and I have no doubt that as such it will in time appear with any addenda that my too generous friends may then see fit to include.

All this was the result of flagrant insubordination on the part of my underlings, my editorial vassals, who filched from me my "massy keys of metals twain (The golden opes, the iron shuts amain)" which I and I alone am privileged to use for admissions to, and exclusions from, the pages of this journal. It will please you to know that

the perpetrators of this reprehensible trick have been thoroughly castigated.

It is only proper that I should inform you about the circumstances under which the photograph came to be taken. My associate, Dr. Peikoff, arrived one morning with a photographer. When I asked him for what purpose he wanted the photo he silenced argument by saying "It's none of your damn business!" When I attempted to remonstrate I was cowed into submission and thereby forced to do my captors' bidding. When next I saw the thing it was in print.

I would not dwell upon myself as a topic but for the fact that many who did me honour were not before me when I thanked them. The magnificent recording device was an unnecessary addition to the illuminated address with its dozens of signatures. That alone was beyond my expectations. Indeed, I sought for nothing and had expected nothing. It is heart warming in the highest degree to realise how many well-wishers I have. Without friends, Croesus was poor. I am poor only in thanks for I can say no more than "Thank you." Yet if it was your purpose to surprise me you will be gratified to know how completely you succeeded, for I had no inkling, or even suspicion, of what was afoot until the denouement.

Education

Greater knowledge is good, but there is a higher ideal—greater love of knowledge. You may frighten people into working harder, but the results will disappoint you, unless you have made them fonder of work. How little it is after all that schools and colleges, even of the highest order, can teach directly. Yet even the humblest of them can do something better. They can develop in their scholars a capacity, and inspire an interest, which will cause them to go through life teaching themselves. This, after all, is the final test of the value of an educational system, whatever its curriculum may be. Is it intelligent? Is it thorough? Above all, is it rousing? Does it excite intellectual interest in those who come under its influence? Does it develop in them the temper which always asks for a reason and struggles to arrive at a principle?

When I look at the augmented list of subjects which now figure in our elementary education, I sometimes fear lest it should lull us into the belief that our object is gained if we can only pile up high enough the number of our studies. The question is, whether they are so taught as to expand the mind, or merely to fill it? Are the

teachers interested? Are they interesting? Do they stimulate as well as inform? Let it not be supposed that I would say one word against the wider range and greater variety of modern studies. Variety promotes interest. But the mere multiplication of subjects is not what is essential. What is essential is the intellectual gymnastic which strengthens the mind to grapple with tough problems, and the intellectual interest which leads men to delight in that exercise. The live mind will provide itself with varied knowledge, as the well-tilled soil will grow all sorts of crops. But on the half-cultivated intelligence the stores of knowledge are lavished in vain, as the best seed is wasted on the unploughed and unharrowed field.—Lord Goschen, Rectorial Address, St. Andrews, 1880.

Report of Nominating Committee

In accordance with Article 11 of the Constitution and By-Laws "The President, First and Second Vice-Presidents, Honorary Secretary, and Honorary Treasurer, and the additional members of the Executive Committee, unless otherwise provided in this constitution, shall be elected at the business session of each Annual Meeting. They shall be elected from nominations, one or more names for each office, to be submitted by the Nominating Committee to the Executive Committee and published in the Association Bulletin at least one month before the Annual Meeting, and from such other nominations as may be made from the floor at the business session of the Annual Meeting." Letters were addressed to the District Societies on April 7th and May 2nd, and notices were despatched on May 31st for a meeting of the Nominating Committee to be held on June 6th. Attendance was small and the following slate was proposed:

President:

Dr. A. M. Goodwin, Winnipeg

First Vice-President:

Dr. C. W. Wiebe, Winkler

Second Vice-President:

Dr. W. F. Tisdale, Winnipeg

Dr. T. E. Holland, Winnipeg

Honorary Secretary:

Dr. C. B. Schoemperlen, Winnipeg

Dr. F. G. Stuart, Winnipeg

Honorary Treasurer:

Dr. R. Lyons, Winnipeg

Dr. L. Cherniack, Winnipeg

Winnipeg Member at Large:

Dr. A. B. Houston, Winnipeg

Dr. J. M. Kilgour, Winnipeg

Rural Member at Large:

Dr. A. S. Little, Dauphin

Dr. J. A. Findlay, Brandon

It was agreed that other members of the Committee be contacted prior to publication of the list in the Manitoba Medical Review. To date, one request for alteration in the list has been received.

Letters to the Editor

230 Elm Street,
Winnipeg, July 23, 1951.

The Editor,
The Manitoba Medical Review.

Sir:

The lack of information in the activities and progress of the Manitoba Medical Service may be attributed to the age-long principle of seclusion held by the Medical Profession. Many citizens, both lay and professional, have to be satisfied with the financial report published annually, and probably this would not be available if it were not a statutory regulation. An organization directly supported by 100,000 citizens is definitely big business, but the bulk of these members do not understand the intricacies of a financial report. Large corporations learned that some time ago, and in order to get the support of their shareholders, they publish reports in which graphs are largely used as being the simplest means of conveying information. This method was employed in a report of the Winnipeg Medical Relief Plan fifteen years ago, and evidence showed that it was appreciated in the States where requests for more copies could not be filled.

The Blue Cross Hospital Plan publishes a very full annual report, though I think that the average citizen would find some of it difficult to interpret. As the education of the public proceeds, its members are taking more interest in the operation of any body which taxes them or to which they contribute. It is quite possible that if the present policy of detachment continues, some day there may be a demand for an investigation by an authoritative group. The diffusion of information from time to time would forestall such action. It would also be very valuable if and when a government decided to embark on a medical service plan.

Yours truly,

E. S. Moorhead.

Color Conscious

Shortly after the June-July issue of the Review made its appearance, one of our staunch Association supporters, a Past-President of less than five years, in fact, called the office and stated that he wished to cancel his membership and receive no more copies of the Review. Completely startled, the loyal office staff member inquired the reason, only to be told that the cover of the Review for June-July was a bright orange colour. The business manager's repartee is, of course, that the March issue of the Review bore a green colour which called forth an outburst of pride on the part of the same loyal lover of the Emerald Isle.

M. T. M.

Association Page

Reported by M. T. Macfarland, M.D.

Highlights of M.M.A. Executive Committee, Wednesday, June 6th, 1951

The total number attending constituted a quorum, and was almost equally divided between urban and provincial representatives.

Fee Committee

Agreement has been reached with Manitoba Medical Service concerning procedure for revision of fees, setting new fees, etc.

1. The fee will be set by the M.M.A. Fee Committee and notification of the change will be sent to the Executive Director, Manitoba Medical Service.

2. If the suggested fee is acceptable to Manitoba Medical Service, notice to that effect will be sent to M.M.A., and the changes will be forwarded for ratification to the Executive Committee of the latter Association.

3. If alterations are suggested by M.M.S. comments will be forwarded to the M.M.A. Fee Committee for reconsideration before being sent to the Executive Committee, M.M.A.

Manitoba Medical Service

Various matters were referred to the Executive Committee. The poor attendance record of the one medical member on the M.M.S. Board was referred to the district medical society which nominated him. Another matter which has prevented extension of M.M.S. to rural areas was the question of liability for costs of referred radiology or for radiology rendered elsewhere than in the professional premises of the rural member physician. The recommendation of the M.M.S. Executive Committee was as follows:

"When radiological services are not ordinarily available in a medical office in the town or village of the patient or physician, claims may be adopted from a physician who has rendered these services in a hospital provided that the locus of such service is not designated as a diagnostic centre under municipal or provincial authority, and further provided that the services are not such as would be covered by the Manitoba Hospital Service Association or by a contract of an insurance plan or scheme for hospital services."

Concurrence of the Association Executive was given, as it also was to the recommendation that:

"Where there is a waiting period for eye refraction tests and a claim is lodged for refraction plus tonometry or visual field examinations, (1) the delayed benefit clause shall also apply to the latter two tests; (2) there shall be a waiting period of one year for liability for the costs of tonometry or visual field examinations."

Yet another recommendation "that the limit of

\$300.00 placed for the claims of a doctor in respect of any one illness for a patient might be deleted" was accepted.

Membership Fees

Notice of motion was given "that, as of January 1st, 1952, any member of the Canadian Medical Association, Manitoba Division, who, having joined originally to a limited membership because of a fixed salary, be required to pay the full membership if he (or she) changes status to that of full or partial private practice within six months of joining."

Workmen's Compensation Board Negotiating Committee

The Committee under the chairmanship of Dr. P. H. McNulty has had several meetings at which representations of groups and individuals have been considered, and the new proposed rates set down opposite the former fees. Modification of existing and new regulations have been requested, and the whole is to be presented to the Commissioner in the near future with the request that same be made effective on or about July 1st. The Chairman is confident that he will be able to report progress to the Annual Meeting in October.

Health Survey Committee

One year ago the Association was invited to participate in a survey to be conducted by the Sub-Committee on Medical Care, Department of Health and Public Welfare. A questionnaire was sent out over the joint signatures of the Association President and Health Survey Director. During the year the information was tabulated, but as is often the case, there was not 100% co-operation by the profession (questionnaires during the summer vacation period are not popular). Several questions were unanswered, or were misunderstood and incorrectly completed and the tabulated results are by no means accurate. Small wonder then, that analysis of the information supplied and conclusions drawn from the survey should not be those which adequately portray the present situation in this province. Of the assiduity and honesty of those whose task it was to advance the survey analysis there can be little doubt. The results of the prodigious effort were received on June 4th and were in the nature of an interim report, complete with tables and maps. A request was made that recommendations, suggestions or comments, indication of approval or otherwise might be made by June 13th. Since members of the Executive Committee were leaving for meetings of the American and Canadian Medical Associations, adequate study of the interim report was not possible, and the importance of the document was considered such that a copy should be sent to each member for perusal and preparation of Association opinion at some later date.

(Continued on Page 461)

the physician can now select
the medication best suited to
his purpose . . .

—the *pleasant*
tasting **ELIXIR**

or

—handy-to-carry **TABLETS**



In nervousness and fatigue,
a judicious combination of
low dosage sedation and
high dosage B-complex
therapy often provides
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Social News

Reported by K. Borthwick-Leslie, M.D.

Hello! After two months some of this is old, some is new. Those I have lost I apologize to—those on week-ends I missed entirely, apologies to you.

Could it be that at last our Eastern brethren have realized the importance of the West, or was it just Pat's personality! Anyway, congratulations to Dr. P. H. McNulty who was appointed chairman of the Trans-Canada Medical Services. This, for your information, is for National Organization for Pre-Paid Medical Care, which is sponsored by the Profession, but does not supplant regional medical care plans. Pat, how is the headache?

Dr. and Mrs. John R. Judge, whose marriage took place in June, are making their home in Pangnirtung, North West Territories. Dr. Judge, a U. of M. graduate, 1950, will be in charge of the Anglican Hospital.

Congratulations to Dr. A. E. Cantelon, Cunningham Ave., St. Vital, who, about the 1st July, 1951, celebrated Fifty Years in the private practice of medicine.

The many friends of Dr. J. Laurie Lamont will be interested to learn that Dr. Thomas A. H. Lamont obtained his F.R.C.S. (Edinburgh) as of June, 1951. He is a graduate of Manitoba Medical College, as was also his grandfather, Dr. T. J. Lamont. Dr. Lamont will be returning to Winnipeg this fall.

Welcome to Dr. W. L. Bell, graduate of London University and St. George Hospital, London, Eng., who has arrived in Brandon to take over as medical director of the Brandon Health Unit.

Dr. and Mrs. Andrew Karsgaard, with their three children, are visiting Mrs. Karsgaard's parents, Mr. and Mrs. Pierce, while on furlough after four years on the staff of the American Mission Hospital in Pakistan.

Dr. and Mrs. Ross Mitchell are back home from a most pleasant and instructive tour of Britain and the Continent. Dr. Mitchell attended the International Conference of Gynaecology in Paris.

Dr. Arthur Hicks retired from his practise in Roblin, Man., in June. He expects to be with his family in Winnipeg. Dr. Edward Otke is taking over in Roblin. Best wishes to both.

Drs. Hugh Malcolmson, Roper Cadham and Gordon Fryer were called to Washington early in June to take part in an International Conference on the medical aspects of atomic warfare. We will be hearing more from them I hope.

Dr. Owen Trainor, Medical Director of Misericordia Hospital, was recently elected President of the Canadian Hospital Council in Ottawa. The Tribune's picture wasn't too photogenic.

Word has been received that Margaret, eldest daughter of the late Dr. and Mrs. O. Bjornson, is now Lady Margaret Elton. Upon the death of the Baronet Elton, Margaret's husband, Sir Arthur Elton, becomes the 10th Baronet. The Ancestral home is in Clevendon, England, 12 miles from Bristol.

Dr. and Mrs. Bruce Wilson, with their children, have sailed from South Hampton, Eng., for New York. En route to Winnipeg they will visit in Coppercliffe, Ont. They have spent the last two years on the Continent and in Africa.

Weddings

The lady doctors have gone active.

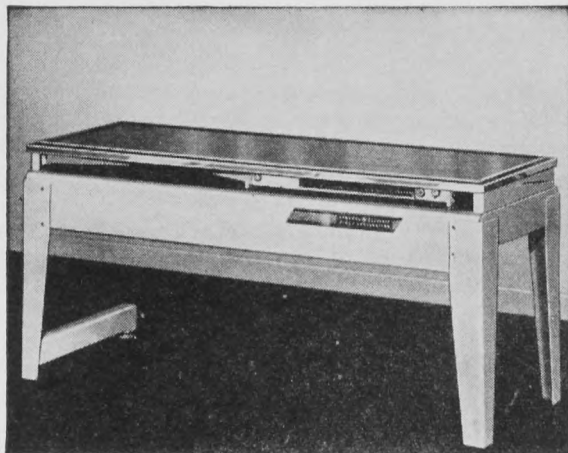
Dr. Helen C. Cameron marries Dr. C. E. K. Cohoe. The bride is the younger daughter of Dr. and Mrs. A. P. Cameron, of Swan River. The bridegroom is the son of Mrs. T. A. Cohoe, of Pilot Mound, and the late Dr. Cohoe. Dr. Jean McFarlane and Dr. Joyce Grace, of Winnipeg, former classmates, were her attendants. The Doctors Cohoe left for Vancouver where they will be staff-members of Shaughnessy Hospital.

Dr. Marion Ruth Mathers became the bride of Dr. Frank Bennett Pearson. The ceremony taking place July 7th in St. Margaret's Anglican Church. The bride is the younger daughter of Mr. and Mrs. S. F. Mathers. The bridegroom is the only son of Mr. and Mrs. F. W. Pearson. After honeymooning at Lake of the Woods they have taken up residence at Royal Oak Court.

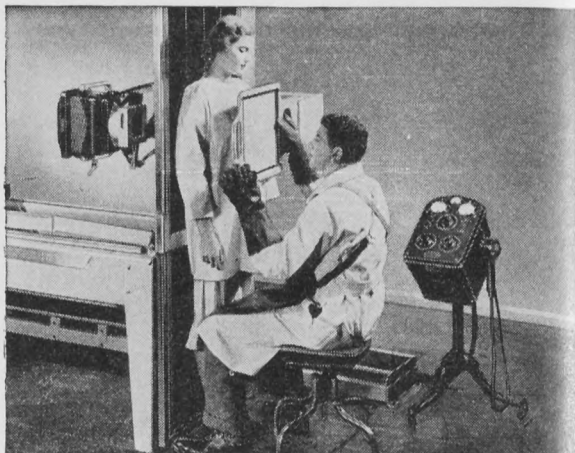
Dr. Joyce Lorraine Findlay became the bride of Michael Kevin Grace, June 9th, in St. Mary's Cathedral. Two of the four attendants were Dr. C. Jean McFarlane and Dr. Helen C. Cameron, fellow graduates of the bride at the 1951 convocation, U. of M. Following a reception in the Fort Garry Hotel the young couple left for a holiday at Clearwater Bay. On their return they will reside in Winnipeg, where the bridegroom is completing his final year in medicine.

(Continued on Page 461)

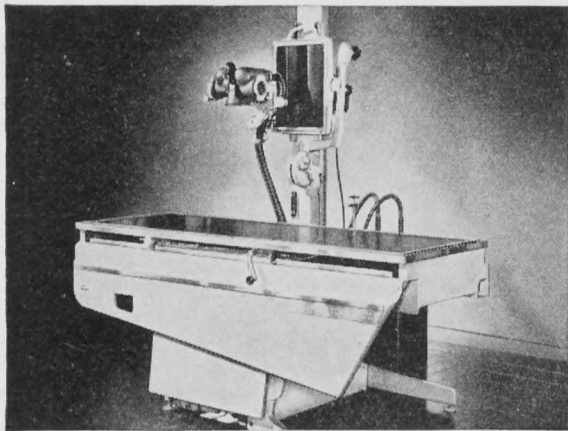
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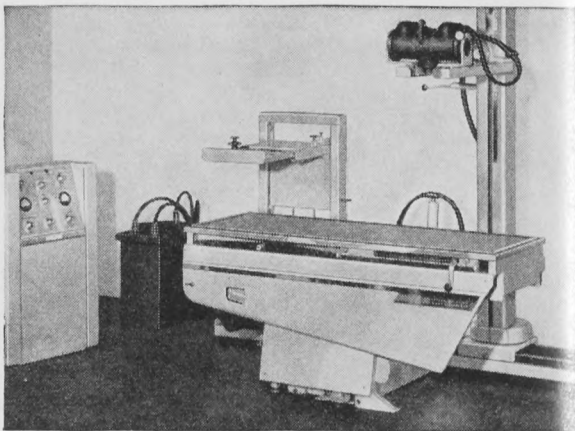
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Social News (Cont.)

Dr. Leonora Hawirko became the bride of Anthony J. Yaremovitch, July 14, at St. Vladimir and St. Olga Cathedral. Dr. Roma Hawirko, sister of the bride, was one of her attendants. That "honeymoon" is being spent in an unknown plane of secrecy—perhaps by now in stratosphere. On their return to earth, Winnipeg will be their home.

Helen Mae McKenzie and Dr. Stanley Charles Windel exchanged wedding vows June 9th in Holy Trinity Church. Dr. Windel is a 1950 graduate of Manitoba Medical College and the bride of 1949 graduate of the Winnipeg General Hospital School of Nursing. They have now taken up residence in the Nelson Apartments.

Knox United Church was candlelighted June 23rd for the wedding of Ethel Craighill and Dr. Frederic W. Duval. The bride was given in marriage by Dr. Allan Davidson. Dr. Duval is a 1950 graduate of Manitoba Medical College. Mrs. Duval is a graduate of the Children's Hospital. They will make their home in Winnipeg.

In Saltcoats United Church, July 28th, marriage vows were exchanged between Doreen MacDonald and Dr. James B. Morison, son of Dr. and Mrs. D. W. Morison, of Winnipeg. Dr. and Mrs. Morison, Jr., left on a wedding trip to Eastern Canada. They will shortly leave for Europe where Dr. Morison has an appointment with the Canadian government.

Welcome to our Juniores members:

Dr. and Mrs. T. Johannesson announce the arrival of David Bruce, June 22, a brother for Jimmy.

Dr. and Mrs. R. M. Heffelfinger of Port Coquitlam, B.C., a son, July 2nd.

Dr. and Mrs. L. H. Katz are happy to announce the arrival of Arlene Ruth, on June 17th (Father's Day?)

Mr. and Mrs. D. A. Kaplan (nee Dr. Florence Treple), are receiving congratulations on the birth of Ross Allan, July 7th.

Dr. and Mrs. W. J. Ranosky announce the birth of Michael Paul, July 10th.

Dr. and Mrs. G. N. Irvine announce the birth of Duncan Norman on June 28th.

Dr. and Mrs. O. Eggertson are happy to announce the birth of Michael Ross on July 15th.

Dr. and Mrs. Darrell F. Osborne announce the birth of a son on July 20, at Inland Hospital, Kamloops, B.C. A brother for Marilyn and Laurel.

Dr. and Mrs. C. D. Lees announce the birth of Georgia Shelby, June 17th.

Dr. and Mrs. C. B. Schoemperlen are happy to announce the birth of their son, July 22nd.

Dr. and Mrs. W. J. McCord are very happy to announce the birth of their son, July 29th. Quote: The name? God knows!

Association Page (Cont.)

Radiologists

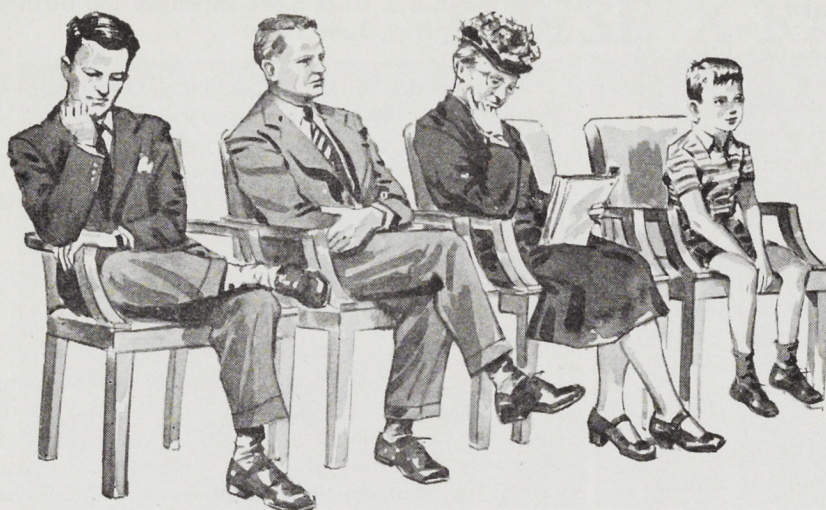
A meeting of the joint committee representing the Association and Radiological Section met on June 5th to consider the bill for incorporation which was proposed at the last session of the provincial legislature. An attempt will be made prior to the Annual Meeting of the Association to present both sides of the argument—"To incorporate or not to incorporate"—a question of vital interest to each and every branch of the practice of medicine.

Canadian Arthritis and Rheumatism Society

Some objection was made of the manner in which a special medical committee had conducted a recent drive for funds from members of the profession. A resolution recommended that the district medical societies should not sponsor any campaign for funds among the profession for any lay society necessitated in any special disease without having such campaign cleared by the Executive Committee of the M.M.A. If the profession is to gain a reputation for generosity in appeals which are made to the public it must be generous!

Society for Crippled Children of Manitoba

A request has been received from the above organization for arguments which favour the payment of fees for medical services rendered to cases in which the Society is interested. Our Code of Ethics says, "While 'God's Poor' should always be cared for with charity it should be understood that the physician gives his services as an act of courtesy but not of obligation." Funds for the Society are derived from different sources, one being voluntary donations to the Easter Seal campaign sponsored by the Kinsmen Club, the other one being from the taxpayer's money assigned by the Federal Government for specific projects. The medical man may contribute to the voluntary appeal, and he may also donate his services voluntarily or at a greatly reduced fee rate, or both, but he is also a taxpayer, occasionally in the higher brackets, and when federal funds are being utilized to pay transportation, maintenance, hospitalization, rehabilitation and other costs (crutches, braces, shoes, appliances, etc.), surely the professional man is worthy of his hire!



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Winnipeg Medical Society

The Medical Society and Its Objectives

Presidential Address

Delivered at the Annual Meeting of the Winnipeg Medical Society, May 18th, 1951, by Kenneth R. Trueman, Retiring President

On this occasion precedent requires that the retiring president of our society present his thoughts on a topic of his own choosing. In the past I have heard papers dealing with local history, philosophy, science and hobbies, offered in an able and an entertaining manner. However, as it approached my turn, the choice of a subject has not come easily, and the selection was finally made with some foreboding for fear of treating it inadequately.

It occurred to me that it is appropriate at a function such as this to examine some of the objectives of our own Medical Society. In the printed constitution its structure appears commonplace enough and properly established. Its rules and regulations resemble those of any group of people who have established a similar type of benevolent organization. There is lacking, however, in the constitution anything to indicate what the aims of the Society are and what principles should motivate our actions. It is here, then, that I have sought to find a basis for discussion.

Fifty years ago Sir William Osler, addressing the Centennial Celebration of the New Haven Medical Association, referred to the value of a medical Society by recalling the principles upon which that Association had been founded a hundred years before. Its founders had written that "their Society was formed upon the most liberal and generous principles, and was designed first to lay a foundation for that unanimity and friendship which is essential to the dignity and usefulness of the profession." To accomplish this, its members were to meet regularly. In all cases where counsel was requisite they were to assist each other without reserve. All reputable practitioners in the district were to be admitted members. These were to communicate their observations and discoveries as they might make in medicine, surgery and other branches of the profession, and deliver faithful histories of the various diseases incident to the inhabitants of their country with mode of treatment and outcome in unusual cases. In those days when organized medical teaching had not developed as we have understood it, a further function of the Society was to examine and pass upon candidates seeking admission, to the profession. These and other objectives were thus set down, and although time has brought many changes, they for the most part hold good today.

It would appear, therefore, that a chief function of a medical society such as ours must be the continuing education of its members, competent as they may be. This is so because medicine as a science is not a static thing. Its advances are tremendous, with the result that practical and applicable knowledge is being uncovered constantly in fields hitherto unknown. Much of this, because of its technical nature, is difficult to absorb unless it is practised in undergraduate or post graduate work. In this respect it is said medicine differs from other professions such as law, where great principles once established change very slowly. These when grasped make the practice of law by the accomplished, a pleasurable experience free from the perplexities characteristic of the varying human pathological states. It is therefore reasonable, because of the continuing growth of medical science, that the graduate of a few years standing, like last year's car, should lack the improvements found on this year's model. As the years slip by the levels of knowledge among the members of the profession change and vary. It will be the exceptional man who can maintain his efforts to keep abreast of the advances even if his interest be limited to a special field. The responsibilities of

a family, the business of earning a living, and the demands of a busy practice reduce the elasticity of the mind. The tendency to overwork and the resultant fatigue may become an excuse to shun laborious reading and the accession of the newer information. This, as already stated, is often not easily interpreted or applicable without some direct teaching. Yet I am forever impressed by the freshness and modern outlook upon medical and other problems, brought to bear by members of our profession, even after several decades of practice. It speaks well for the keen interest and scholarship they must possess as the basis for their success. But the difficulty exists, and must touch us all to some degree. In this regard, the situation perhaps may affect the general practitioner more than his colleague within a specialty, for the consultant must keep up in his narrower field since the very competitive nature of his practice soon discloses his shortcomings. The practitioner, on the other hand, meets a greater variety of problems, and often under conditions which work to his disadvantage. His capacity for wrestling with these adversaries may mean the difference in the first encounter between a victory and the loss of his patient. If a loss follows, there is none but himself to judge the odds of the struggle. Interest and devotion by the doctor to the case mean much to the relatives of the one who is stricken, and they are satisfied. However, it is the doctor with his own thoughts who, as a rule, really knows whether or not the failure could have been averted by the application of greater effort or a new method of treatment he has not yet grasped.

In this respect, the local medical society may have its greatest value. For a large proportion of its members it can be, as Osler said, a clearing house where a doctor can take stock of himself, keep up with the times, and refurnish his mental shop with the latest wares. Certainly it is a place for the exchange of ideas. Wingate M. Johnson, in his address at the Canadian Medical Association meeting in Saskatoon in 1949 on the Training of a General Practitioner, advised younger doctors to attend medical meetings carrying their most important medical problems, and not to hesitate to seek the opinion of any doctor, no matter how great his reputation. Despite the joking utterance I have heard attributed to Dr. Charles Mayo that he be protected from the man who has a "case," Johnson feels that the best known men are the most easily approached, and are glad to impart any information in their power. Often one can learn more from a few minutes of informal discussion than from the regularly scheduled papers. The older man, in trade for his clinical experience, will get as a fair exchange, information about the newer laboratory methods, the latest discoveries in vitamins and antibiotics, and the constantly changing nomenclature for pathogenic organisms from his younger colleagues. The essence of a medical society, then, is as Osler described it, a school in which the scholars teach each other.

In this matter of education, the Winnipeg Medical Society may regard itself as fortunate. Its members consist not only of practising physicians, but also members of the faculty of Medicine of our University, including the basic science departments. This provides an excellent opportunity for our programme committees to present a happy and interesting blending from the laboratories, the clinical departments, and the practical experience of the doctors at large who are daily applying the newer methods in their work.

An additional contribution by the faculty to the value of our meetings can be by demonstration of instructive specimens in anatomy and pathology. This has been initiated this year, enjoyed and accepted and, it is hoped, will continue as a special feature. Something may be learned from almost any case if it be presented with a view to illustrate the relation of disturbed function to diseased tissues. This year also it gave many of us pleasure to see this Society for the first time



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¹ Friedlaender, A. S. & Friedlaender, S.,
Ann. Allergy, 6: 23, 1948.

sharing in a concrete manner the costs of the Post-Graduate Refresher Course under the auspices of the Medical School. The funds made available by this body helped make it possible for the committee in charge to extend the course, not only for the benefit of the many doctors from rural areas who attended, but for the members of the Society. The latter had the opportunity of hearing the visiting speakers at several luncheon sessions, as well as at a special meeting of the Society. The very large attendance on these occasions indicates an active and intelligent interest in medical education, and it is trusted this precedent is maintained, as it must be to our very great advantage.

In addition to the objectives of the Society in the matter of education for ourselves, there is another which should engage the attention of the profession to an extraordinary degree. However, in these times of great fluctuations in world affairs, it is possible that too many of us have come to lack interest or understanding in what some leaders of the profession describe as a threat to freedom in the practice of medicine. That such a threat is real is demonstrated by the presence of socialized medicine in Great Britain today. Whatever the factors responsible for its presence, the impression received is that it has produced an unhappy situation breeding discontent, especially among the rank and file of the profession of that country. It has among other things disrupted considerably the principles of practice which constitute much of the attraction to those entering the profession. That such a state of affairs may never be our lot is our great hope. Nevertheless, the possibility of some change in the status of our profession has been obvious for a number of years. In this country and in the United States even before the Second Great War, a demand was arising for more comprehensive care for all classes of people and for an effective means of budgeting its costs. Now with living costs rising generally, an additional outlay for a serious medical or surgical illness would be intolerable for many unprepared for such an emergency. In a reverse manner, one can conjecture a similar plight affecting a large proportion of our population should depression follow inflation, and reduced wages and unemployment make the meeting of medical expenses onerous or impossible. The answer, as far as we are concerned, to much of this lies in the policy of the Canadian Association formulated in 1949 at Saskatoon. It is in our interest to encourage the establishment of voluntary prepayment plans for all those who can protect themselves at a moderate cost. The indigent or near indigent can continue to receive medical care free as is the case at present, or what would be better would be the use of a voluntary prepayment service by the government in such a manner as to provide the indigent with its benefits.

The Manitoba Medical Service was instituted by the profession of this province as a solution to the great cost of medical care including investigation. It was also instituted as an answer to possible governmental action to adopt health measures as might be found in a welfare state. With the passage of a few years, this plan has become increasingly popular in Winnipeg. Now it is being extended through the province until over 100,000 people have availed themselves of its benefits. It must be recalled that the measures accepted by the profession in support of the Manitoba Medical Service were undertaken with full knowledge that they would invariably lead to lower rather than higher fees for ourselves. On the other hand, a function of the scheme is to reduce the incidence of bad debts, with the result there tends to be a more favorable return for the doctor. The presence of persons participating in the scheme whose resources would easily permit them to pay even more than the usual fee is often a source of criticism of the scheme. No plan can ever be completely satisfactory. Such exceptions cannot affect the over-all picture in our medical economics to a large degree. We deal with a population where there are many modestly well-off but relatively few are rich. Let us regard with favor rather than criticism our very fortunate present position, if it may be

thus expressed and let this picture be contrasted with the bleak, low income days of the thirties. Granted much of this follows the unparalleled prosperity of this country today. On the other hand, it is partly due to the increasing interest in participation in prepaid medical services offered by ourselves or insurance companies. Furthermore, the duration of such good fortune is uncertain. A glance at history from the times of the Assyrians and the ancient Egyptians to our own era reveals that good times are invariably followed by bad times. Therefore, in the future, should hard times overtake us, it will be to our advantage if a large part of our patients are protected through a low cost scheme they can continue to maintain, assuring their prompt request for attention if illness strikes and a proper return for the doctor through a successful scheme of our own design.

If on the other hand, in the presence of less fortunate circumstances we have neglected one plan or are divided in opinion as to its advantages, it may be easier for the government at that time to apply a plan of its own. Nor would the government be called to bear the responsibility alone. Legislation would only follow the demand for it by some sizeable part of the population, for the Canadian people are politically responsible for the actions of their government. Despite the good the medical profession has achieved, there are those in high places who, for one reason or another, would favor some measure of control over its activities. Doctors are not always, especially as a profession, regarded in a favorable light as we like to believe, although as individuals they may be greatly loved or respected. This idea may recall the experience of the American medical officer in the last war who, for the sake of good international relations, was entertaining his rather aloof opposite number in the British Army. With the dispensing of the proper number of drinks, the Englishman became more cordial. By the end of the evening he was moved to say something like this: "I loathe all Americans, old boy, except the ones I know." And so it may be with us.

Unanimity of opinion in this matter of directing our affairs should become an objective of prime importance to this Society. The Manitoba Medical Service is an answer to socialized medicine. As a function of the Manitoba Medical Association, the plan requires and deserves our full support. It should be protected in all ways against any petty or selfish motives which may activate some minority of our members. At the same time, reasonable suggestions for the correction of what may be unfair handling of certain minority or other groups should be properly considered. It is fair to suppose at this juncture in the schemes' existence that inequalities do exist which lead to dissatisfaction. Appropriate changes no doubt will come as a process of evolution, but they must not be permitted to lag unduly. In this plan the preferential treatment of part of the members as against others can create an issue which is capable of its destruction and lead to a serious division in the profession. To avoid this, I beg to suggest to the incoming Executive that they make it their business to keep us enlightened as to the progress of our scheme. This should include not only reference to its position as it moves in the stream of federal and provincial health policies, but the airing of difficulties encountered by it in relation to ourselves and our patients. By brief reports made, in addition to the scientific presentations at our regular meetings, as well as through the annual report at the Manitoba Medical Association Convention, we will be able to assess its status. This matter and the current trends in medical practice generally should be subject to frequent review. They should never be forgotten if the Winnipeg profession is to play its part intelligently in the decision which likely will be forthcoming in the future. If they are neglected, let none blame any but himself, as Harris McPhedran says, if doctors in the country are presented with a provincial or national programme devised by those who know little of the practice of medicine and less of human beings.

In this discourse nothing has been said about other interests which should be nurtured by our Society. One of these



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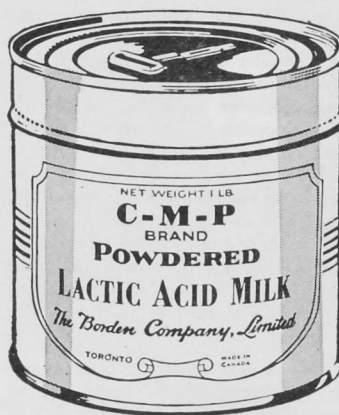
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the maintenance or support of a library. In our Society it is impractical to provide one for ourselves. An excellent alternative has been to share the costs of maintenance with the Medical College Library. Our contribution to it has increased with spiralling costs of upkeep, books and journals. The Society has also undertaken to meet the costs involved in keeping the library open during the evenings for the use of doctors. It is gratifying to note the increasing interest in this service and the medical school, through the library, as an educational centre. It is hoped that in the not too distant future additions to the Medical College will include larger and perhaps more attractive library facilities. At that time, too, a proper assembly hall is envisaged, the lack of which we all recognize. When that time comes, it would appear reasonable that this Society share in some noteworthy

manner the expenses required to produce surroundings worthy of the dignity of the profession.

In conclusion, may I say that our Society should be to all of us a great medium for establishing friendship among ourselves. It can only be from our knowledge of each other that mutual trust and confidence can arise. These are sovereign qualities. We must possess them if we are to remove malice or distrust from our relations with our colleagues in a profession where rivalry is always present to some degree. Bickering and unjust criticism must not mar the usefulness and unity of the profession. At no time should they be more jealously guarded than in this changing world. By the development of closer bonds between ourselves, and as long as we apply our science, kindness and understanding for the benefit of our patients, we can remain strong.

Committee Reports

Secretary

To the President and Members of
The Winnipeg Medical Society:

IN MEMORIAM

Moments of silence were observed in honor of those members who have passed away during the past term of office. They were Doctors Frank W. Boyd, M. Ellen Douglass, O. G. Hagur, Bruce Hill, A. G. V. Leishman, G. Stuart Musgrove, D. G. Ross (Bracebridge, Ontario), H. M. Speechly, B. A. Victor and J. L. Wiseman.

MEETINGS

During the past term your Council held eight meetings, there were four regular general meetings and two special meetings.

The first of the latter was the evening at the Children's Hospital, and the second, in conjunction with the Post-Graduate Course, was held in the Broadway University Building.

The attendance at all meetings was very gratifying. Internes have accepted the invitation to attend General Meetings.

A special dinner was held at the Manitoba Club in honor of Dr. Johannes Clemmesen of Denmark, in January. Following this meeting the "Visitors' Register" Book again disappeared. We earnestly request its return!

NAME PROJECTOR

The brain-child of Dr. Harry Williams has been in use and has proven of great value. We acknowledge our indebtedness to Dr. Williams.

GORDON BELL MEMORIAL LECTURES

It was decided that these lectures would be held at intervals designated by the Council.

MANITOBA FLOOD RELIEF FUND

Last Spring offers of financial help were received from various Medical Societies in Canada. These were forwarded to the Relief Fund authorities.

NATIONAL DISASTER SERVICE INSTITUTE

Doctor Macfarland acted as our representative to this Institute, whose meeting took place at the Royal Alexandra Hotel, and submitted a report.

PUBLIC RELATIONS

Dr. Macfarland reported that Doctors F. G. Allison and L. A. Sigurdson, publicity representatives, M.M.A., submitted a statement to the Press explaining the qualifications required for registration in Manitoba. This was necessitated by the publicity given to the question of importation of foreign doctors.

ANATOMICAL AND PATHOLOGICAL DISPLAYS

Our President, Dr. Ken Trueman, instituted the pre-meeting display of these specimens. This has proven a very

popular adjunct to the general meetings.

CANADIAN SOCIETY OF LABORATORY TECHNOLOGISTS,

MANITOBA BRANCH

In response to a request, financial assistance was given to this organization whose National Convention will be held in this city in June.

ADDRESSOGRAPH MACHINE

The Winnipeg Medical Society shared part of the cost of a new machine purchased by the Manitoba Medical Association. We will be granted the use of this addressograph. Respectfully submitted.

M. M. Brown,
Secretary.

Treasurer

To the President and Members of
The Winnipeg Medical Society:

Herewith certified financial statement from our auditors, Messrs. Thornton, Milne and Campbell.

All of which is respectfully submitted.

Marjorie R. Bennett,
Treasurer.

Dear Sirs:

We have examined the accounts of the Society for the year ended 30th April, 1951, and submit herewith our report thereon together with the following relative financial statements:

EXHIBITS:

"A" Statement of Revenue and Expenditure for the year ended 30th April, 1951.

"B" Balance Sheet as at 30th April, 1951.

Revenue and Expenditure

The operations for the year, as set forth in Exhibit "A," have resulted in an excess of revenue over expenditure of \$1,118.27. Membership fees received are in accordance with duplicate receipts examined by us but are not subject to further verification. Adequate vouchers have been examined in substantiation of all expenditures.

In accordance with the minutes of a Council Meeting of 13th November, 1950, the sum of \$750.00 has been placed in the Special Library Fund for the use of the Library Committee of the Faculty of Medicine. A statement of the transactions affecting this account during the year is also shown on Exhibit "A."

Balance Sheet

In our opinion the balance sheet submitted and marked Exhibit "B" is properly drawn up so as to exhibit a true and correct view of the state of the affairs of the Winnipeg Medical Society as at 30th April, 1951, according to the best of our

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(Rosset and Flexner; Ann. Int. Med., 1944).

● ANTISPASMODIC

HOMATROPINE METHYLBROMIDE*0.1 grain in 1 fluid ounce*

Relieves spastic pain without producing undesirable side effects.

● SEDATIVE

BUTYLBARBITURIC ACID*0.666 grain in 1 fluid ounce*

The barbiturate of choice for prolonged daytime sedation. May be administered in presence of renal damage and is nontoxic to the liver.

(R. D. Dripps; J.A.M.A., 1949).

ANCATROPINE GEL

*Supplied in
12 fluid ounce
dispensing bottles*

Average Adult Dose:
1 to 2 teaspoonfuls

Other ANCATROPINE products of outstanding Merit:

ANCATROPINE Compressed Tablets

Homatropine Methylbromide	1/25	grain
Phenobarbital	1/4	grain

ANCATROPINE INFANT Soluble Tablets

Homatropine Methylbromide	1/250	grain
Phenobarbital Sodium	1/8	grain

ANCATROPINE ALKALINE Compressed Tablets

Dried Aluminum Hydroxide Gel.	10	grains
Magnesium Hydroxide	5	grains
Homatropine Methylbromide	1/40	grain
Phenobarbital	1/6	grain



Anglo-Canadian
DRUG COMPANY LTD., Oshawa, Canada



information and the explanations given to us and as shown by the books of the Society. We have received all the information and explanations which we have required.

We obtained from the Bank of Toronto verification of the bank balances, subject to allowance for outstanding cheques as shown by the books.

Your holding in Government of Canada bonds has been increased by the purchase during the year of \$1,000.00 Government of Canada 3% bond due 1st September, 1966, at a cost of \$976.25. As at 30th April, 1951, the Society's investments are as follows:

Par Value	Cost	Market Value
\$1,000.00 Government of Canada 3% 1957, \$1,000.00	\$ 987.50	
4,000.00 Government of Canada 3% 1966, 4,042.50	3,885.00	
\$5,000.00	\$5,042.50	\$4,872.50

These securities are lodged with the Bank of Toronto for safekeeping and are in accordance with confirmation received from the Bank. All interest, on a received basis, has been duly accounted for on the books of the Society.

In so far as we have been able to ascertain all liabilities applicable to the year under review have been recorded on the books.

In conclusion, we wish to express our appreciation of the courtesies extended to us during the course of our audit.

Yours very truly,

THORNTON, MILNE & CAMPBELL,
Chartered Accountants.
Exhibit "A"

Statement of Revenue and Expenditure For the year ended 30th April, 1951 General Funds

REVENUE

Annual Dues:	
Current Year—Active Members	\$3,575.00
Associate Members	12.00
Prior Years	265.00
	<u>\$3,852.00</u>
Bond Interest	120.00
	<u>\$3,972.00</u>

EXPENDITURE

Audit Fees	\$ 25.00
Bank Charges	9.17
Benevolent Fund Expenses	3.89
Catering	88.92
Donations	1,354.00
General Expense	76.33
Lantern Slides Expense	50.00
Man. Med. Association (Secretarial Services)	900.00
Office Equipment	47.50
Printing, Stationery and Postage	272.42
Telephone Expense	26.50
	<u>2,853.73</u>

Excess of Revenue over Expenditure \$1,118.27

Library Fund

REVENUE

Appropriated from General Surplus	\$ 750.00
Bank Interest	9.21
	<u>\$ 759.21</u>

EXPENDITURE

Books purchased	\$ 701.12
Library Supervision	150.00
	<u>851.12</u>

Excess of Expenditure over Revenue \$ 91.91

Exhibit "B"

Balance Sheet As at 30th April, 1951

ASSETS

Cash:

On deposit with the Bank of Toronto	\$1,360.28
Investments—at Cost:	
Government of Canada Bonds	\$5,042.50
Accrued interest thereon	4.68
	<u>5,047.18</u>
	<u>\$6,407.46</u>

Special Library Fund:

Cash:

On deposit with the Bank of Toronto	886.45
	<u>\$7,293.91</u>

LIABILITIES

Membership Fees Paid in Advance	\$ 22.00
Reserve for Entertainment Expense	45.80
	<u>\$ 67.80</u>

Surplus:

Balance as at 30th April, 1950 \$5,971.39

Add:

General Funds—Excess of Revenue over Expenditure, per Exhibit "A"	1,118.27
	<u>\$7,089.66</u>

Less:

Appropriated for Library Fund	750.00
	<u>6,339.66</u>
	<u>\$6,407.46</u>

Special Library Fund Reserve:

Unexpended balance 30th April, 1950 \$ 978.36

Less:

Excess of Expenditure over Revenue per Exhibit "A"	91.91
	<u>886.45</u>
	<u>\$7,293.91</u>

Benevolent Fund

To the Members,
The Winnipeg Medical Society Benevolent Fund,
Winnipeg, Manitoba.

Dear Sirs:

We have examined the accounts of the fund for the year ended 30th April, 1951, and submit herewith our statement pertaining thereto:

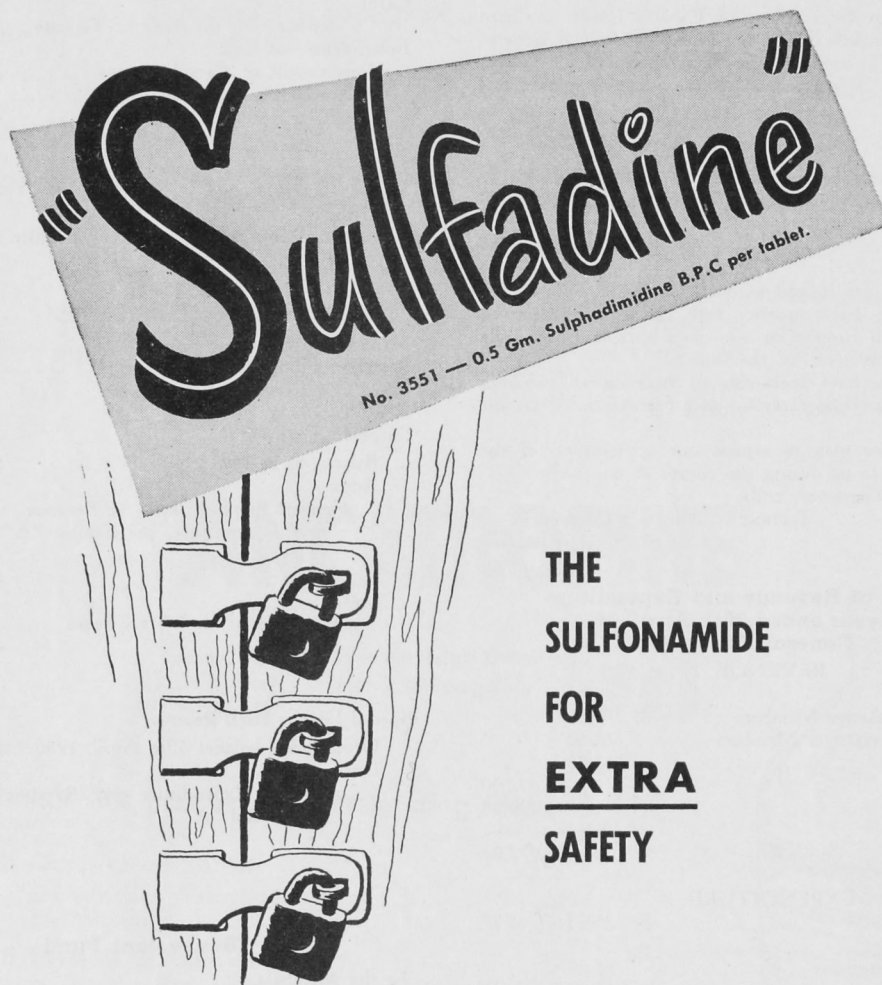
Cash on deposit in the Bank of Toronto, 30th April 1950	\$2,036.00
Add: Receipts for the year	806.45
	<u>\$2,842.45</u>
Less: Disbursements	423.70

Cash on deposit in the Bank of Toronto, 30th April, 1951 \$2,418.75

Donations received are in accordance with duplicate receipts examined by us. All disbursements made were under the signatures of authorized signing officers of the fund.

Yours very truly,

THORNTON, MILNE & CAMPBELL,
Chartered Accountants.



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SULFONAMIDE
FOR
EXTRA
SAFETY

QUICK, HIGH BLOOD LEVELS — *by rapid absorption.*

EXTREMELY SOLUBLE — *no need for alkalinization or high fluid intake.*

SAFE — *renal toxicity practically eliminated.*



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Report of Trustees

To the President and Members of

The Winnipeg Medical Society:

As Senior Trustee, I wish to report the following securities as being held in Safety Deposit Box, Bank of Toronto, 394 Portage Avenue:

Dominion of Canada Bond, 3%, due 1st May, 1957	\$1,000.00
Dominion of Canada Bond, 3%, due 1st September, 1966	1,000.00
Dominion of Canada Bond, 3%, due 1st September, 1966	1,000.00
Dominion of Canada Bond, 3%, due 1st September, 1966 2X \$500.00	1,000.00
Dominion of Canada Bond, 3%, due 1st September, 1966	1,000.00
Balance on Deposit, Bank of Toronto, as at April 30th, 1951	1,360.28

The aforesaid Bonds and Bank Deposit have been vouched for in the Auditor's Report.

I have personally inspected the office equipment of the Society at 604 Medical Arts Building, the equipment in the Manitoba Medical College in the custody of the Caretaker, and Lantern in care of Mr. Gordon Axtell, and found them to be as listed herein:

Office Equipment at 604 Medical Arts Building:

1 Steel Filing Cabinet, 3 drawers; 1/3 Interest in Elliott Addressing Machine; 1/3 Interest in Mimeograph Machine; 1/3 Interest in Underwood Typewriter, 14" Carriage, Serial No. 5732553-14; 1/3 Interest in "Copy-right" Holder; 1/3 Interest in Burroughs Adding Machine.

Equipment in Manitoba Medical College in custody of Caretaker:

12 Wooden Chairs; 4 Wooden Trestles and 2 Wooden Table Tops for same; 32 Cups and Saucers; 1 Coffee Urn; 1 Gavel, this Gavel made from wood from the ruins of the Royal College of Surgeons and presented to Winnipeg Medical Society by Dr. John C. Hossack; 1 Plaque, Honour Roll of Past Presidents (in Physiology Lecture Room of the Medical College), book value \$218.64.

In Care of Mr. Gordon Axtell:

1 Delinoscope Lantern, Model OJR, No. 3647, made by Spencer Wells Co. of Buffalo, New York, and one spare bulb for same. Estimated value \$250.00.

K. Borthwick-Leslie,
Senior Trustee.

Membership Committee

To the President and Members of

The Winnipeg Medical Society:

The present total membership of this Society is 446, made up as follows:

Active Paid-up Members	364
Associate Paid-up Members	5
Non-Resident Paid-up Members	2
—	371
Life Members	21
Non-Active Members	12
Complimentary to end of season	5
Membership Fees not fully paid	37
—	75
—	446

Thirty-two members have been lost to the Society during the year, 11 being deceased and 21 having left the city. Four of this number had paid dues during the current year and 3 were Non-Active and Life Members, so that the actual loss in dues was 25 in number.

Twenty-six names have been added to the Society membership roll during the current year.

This makes a total of 446 members for 1950-1951 as opposed to 452 for 1949-1950—a decrease of 6. However,

there are 371 paid-up members this year as opposed to 369 last year.

An effort was made during the current year to see that every member of the Society had paid his dues in full. In connection with this, a letter was sent to every member who had defaulted payment for one or more years. This was productive of some results but after the smoke had cleared there were still a number of unpaid accounts.

The machinery for dealing with a member whose dues are unpaid is outlined in Chapter III, Section 3 of the Constitution and By-laws of the Winnipeg Medical Society, which states:

"In January of each year it shall be the duty of the Secretary and Treasurer to present to the Council a roster of all members of the Society, upon which shall be indicated all those whose dues are unpaid. It shall be the duty of the Treasurer to draw forthwith upon each member for the amount due by him to the Society. On the first of September of the same year the Treasurer shall report to the Council those whose dues are still unpaid. Any name on this list shall be suspended from the roster of the Society, but may be restored to membership by the Council on the payment of arrears or two years' dues, whichever is the lesser."

It is felt that this method is somewhat impractical and cumbersome, and it is suggested that consideration be given by the incoming Council to a change in Constitution, whereby a more realistic policy is adopted.

It is also suggested to the incoming Council that all members in good standing who have attained the age of 65 be excused from payment of any further fees, and be afforded the privileges of the Society for the remainder of their lives.

It is recommended that a committee be drawn up to explore these suggestions.

Respectfully submitted.

David Swartz,
Chairman.

Programme Committee

To the President and Members of

The Winnipeg Medical Society:

During the past season a total of nine meetings of your Society have been held. At seven of these meetings the programme was put on either entirely or largely by our local doctors.

As in the past an effort has been made to provide some variation in the types of programmes presented. However, the "Country Fair" type of hospital demonstration still seems to be one of the most popular events. This year it was very ably directed by the Honorary Attending Staff of the Children's Hospital.

I am most grateful for the co-operation of all who were concerned in the preparation of the various programmes and particularly to Dr. Medovy, my predecessor, who gave me several helpful suggestions for possible programmes.

October 20, 1950—

The Tisdall Memorial Lecture.

"The Trends in Anaesthesia at the present time in Britain,"

Dr. John Gillies, Director, Dept. of Anaesthesia, Royal Infirmary, Edinburgh.

"Multiple Primary Carcinoma of the Colon"

Dr. P. H. T. Thorlakson

November 17, 1950—

"Some Problems in Paediatric Clinical Diagnosis."

Case I

Drs. Murray McLandress, Jan Hoogstraten

Case II

Drs. Kenneth Martin, Jan Hoogstraten

December 15, 1950—

The Defence Medical Association.

Speakers

Dr. Roy W. Richardson

Lt.-Col. G. L. Morgan Smith

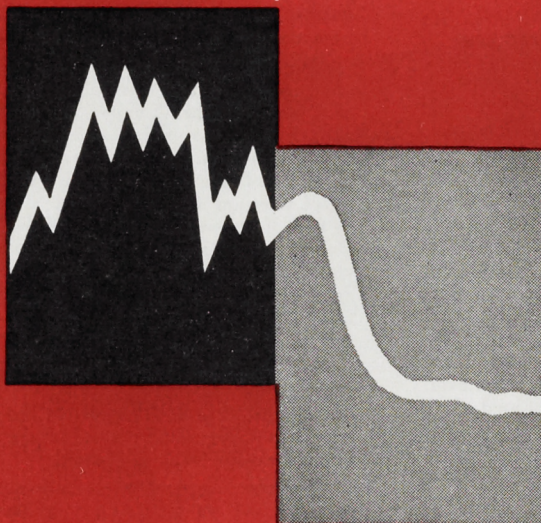
"Medical Aspects of Civil Defence"

January 19, 1951—

"Round Table Discussion on Headaches"

Moderator

Dr. A. B. Houston



bardona

capsule pentobarbital and belladonna
sedative, antispasmodic

Effective as a sedative in heightened nervous conditions which frequently accompany gastric conditions such as nausea and vomiting as in seasickness, pregnancy, vertigo and migraine.

EACH CAPSULE CONTAINS:

Sodium Pentobarbital - - - ¼ gr.
Powdered Extract Belladonna B.P. ¼ gr.

(Equal to 8 mins. Tincture)

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ETHICAL PHARMACEUTICALS



Professional Representative: Mr. J. R. Hope, 264 Lindsay Street, Winnipeg, Man.

Other members of Panel, Doctors Dwight Parkinson, John Burch, Walter Alexander, Lennox Bell.

January 23, 1951—(Special)

"The Endemiology of Cancer" Dr. Johannes Clemmesen
Secretary Sub-Committee on Cancer of the Expert Committee on Health Statistics, World Health Organization.

February 16th, 1951—

Children's Hospital: Series of exhibits by members of the attending staff.

March 29, 1951 (Special)—

(In conjunction with the U. of Man. Refresher Course).

"Intestinal Obstruction" Dr. W. C. MacKenzie
Professor of Surgery, University of Alberta.

"Medical Diseases of Bone" Dr. Ray Farquharson
Professor of Medicine, University of Toronto.

April 20, 1951—

Series of Short Papers: Doctors I. MacLaren Thompson, Wm. Perry, Wm. Fyles, J. E. Newell, Frank White.

May 18th, 1951 (Annual)—

Address by President and Reports of Committees.

Respectfully submitted.

F. Hartley Smith,
Chairman.

Standing Legislative Committee of Fifteen

To the President and Members of

The Winnipeg Medical Society:

Two meetings of the Committee of Fifteen were held in the past year. The first meeting was held in October, 1950, to discuss the Workmen's Compensation Act. It has been learned that the Minister of Labor was forming a Committee of the House to receive briefs from interested groups such as Labor, Management, etc., such briefs to contain recommendations for amending the Act. The meeting was held in the Medical Arts Club Rooms, and Dr. D. J. Fraser was invited to attend. It was soon found that a comprehensive analysis of the entire Act was not feasible for such a large group, so after some rather spirited discussion, the meeting decided to appoint a sub committee to study the Act and prepare the desired brief.

This Committee consisted of: Dr. M. T. MacFarland, ex officio, Dr. F. D. McKenty, Dr. Henry Funk, Dr. Ross Cooper.

The sub-committee held several lengthy meetings, and were very fortunate to have Dr. McKenty's help, for probably no one in the profession has studied the Compensation Act as he.

A brief was finally prepared and passed to Mr. Laidlaw, our solicitor, who presented it before the House Committee. It became apparent that there were many features of the existing Act that were unreasonable, unpopular with the profession and obsolete.

Points recommended in our brief were:

1. The adoption of the Manitoba Medical Association fee schedule.

2. That the medically trained personnel of the Board be increased in order that disputes over methods of treatment, needs of workmen, and the appraisal of physicians' accounts can be reduced to a minimum, and thus avoid the possibilities of friction between the individual physician and the Board.

3. A closer liaison between the profession and the Board, even to the extent of having a duly qualified medical practitioner as a member of the Board.

4. The desirability of setting up a representative committee to deal with cases in which medical evidence has a definite bearing on the establishment of the claim of the applicant and contentious matters arising therefrom.

5. An extension of the reporting time in cases of hernia.

6. Further study of the problem of rehabilitation of the injured workman both from remedial and from occupational standpoints.

In passing, it is noted that none of the recommendations contained in our brief were included in the amendments to

the Act passed at the recent session.

A second meeting was held late in March, 1951, to discuss legislation by which the radiologists were proposing to incorporate. This information reached us after the private bill dealing with this matter had received first reading. At the meeting Doctor Childe and Dr. McCulloch were invited to be present to explain their reasons for such a step. It was felt by the Committee that the time was inappropriate for such incorporation, and a resolution to this effect was passed and forwarded to the College of Physicians and Surgeons, and the Manitoba Medical Association.

When the radiological section became fully acquainted with the views of the profession, they withdrew their bill, although it is understood, with the intention of proceeding with the incorporation of their section at a later date.

No other meetings of the Committee of Fifteen were held.

All of which is respectfully submitted.

Ross H. Cooper,
Chairman.

Representative to Executive Committee, Manitoba Medical Association

To the President and Members of
The Winnipeg Medical Society:

The executive of the Manitoba Medical Association have held regular monthly meetings from October, 1950, to April, 1951. All except the April meeting were held on Sunday afternoons. Most of them were lengthy and one of them lasted for five hours.

Many subjects of interest to the Winnipeg Medical Society were discussed but the following seem the most important.

Civil defence was considered at length but to date no final action has been taken owing to lack of complete organization by the Dominion and Provincial authorities.

Dr. J. C. Hossack, Editor of the Manitoba Medical Review, was invited to attend the January, 1951 meeting. As is well known, Dr. Hossack has performed an onerous task for years, in a very able and conscientious manner. Through his efforts, the Manitoba Medical Review has become a very successful publication. He pointed out that he was having considerable difficulty in obtaining sufficient and proper material for the journal. To help alleviate some of his difficulties, the President of the Winnipeg Medical Society has appointed Dr. J. R. Mitchell as representative from the Winnipeg Medical Society to the editorial staff of the Manitoba Medical Review. It is essential that the appointment of such a representative be continued from year to year, so that the Review receives news of our Society.

As an additional measure to provide material for Dr. Hossack, the Manitoba Medical Association is now considering the purchase of a tape recording machine. They hope that the Winnipeg Medical Society will share part of the cost of this equipment even though its main purpose will be to record the various papers presented at the Winnipeg Medical Society meetings with a view to subsequent publication. The exact type and cost of such a recorder are still being investigated.

Respectfully submitted.

Arthur E. Childe,
Representative.

Library Committee

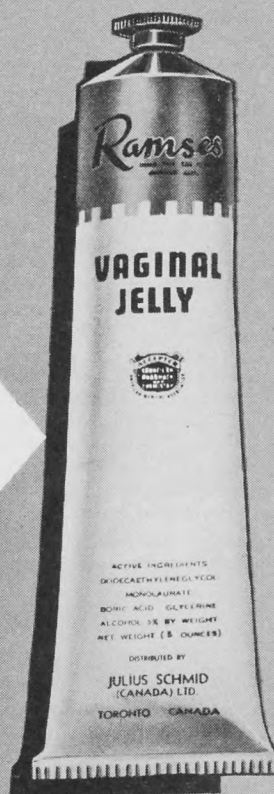
To the President and Members of
The Winnipeg Medical Society:

It has been my pleasure another year to represent this Society on the Library Committee of the Medical School.

The Medical Library has again had a busy year. The Red River Flood of 1950 virtually took a month out of the professional life of most city doctors, and this was reflected in the patronage of the Library. A total of 12,095 loans were made

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during the past year, whereas the previous year the number of books and journals borrowed was 13,039. The figure for 1921-1922 was a total of 1,890 items. As usual, about half the doctors of the city made use of the Library. The remainder, presumably, have such well-stocked bookcases at home that they do not require our Library facilities.

A third year of experimentation with evening Library hours must be reported. From December to March, inclusive, the Library was kept open five nights a week, from eight to ten p.m. Fifty graduates and thirty-six students made 164 recorded visits. Last year the same number of patrons made 187 visits. It is a question whether keeping the Library open twenty-five evenings, with an average patronage of two visitors per evening, justifies the expenditure of one hundred and fifty dollars for this service. An expression of opinion from the membership might guide the Executive in their formulation of policy for next year.

The grant of the Medical Society to the Library permitted the purchase of eleven volumes of new books, three series of journals, and the binding of seventy-seven volumes. This comprises about one-quarter of the total volumes purchased, exclusive of subscriptions to loose-leaf systems. The effect of inflation is strikingly seen in the increased cost of Library maintenance. For example, the nine titles published by the American Medical Association to which the Library subscribes have increased in price from \$97.00 in 1947 to \$158.00 in 1951. Chemical Abstracts, formerly \$20.00, is now \$60.00. Another result of the high cost of production is the printing of very few extra issues of a journal by the publishers. This means that in most instances a lost issue is almost impossible to replace. It becomes all the more urgent, therefore, to see that journals are bound as soon as a volume is complete.

With a view to increasing interest in the potentialities of the Library, Miss Monk has suggested the placing of a book and periodical display on a truck in the hallway at the time of meetings of the Society. A member of the Library staff would be in attendance to register the borrowing of books before the meeting. This proposal appears to have merit, and I recommend that it be discussed by the incoming Executive.

The members of this Society who use the Library are proud, I am sure, of the status it has attained. In two respects particularly are we well served. The collection of 18,000 volumes comprises a splendid assortment of up-to-date text books, monographs and journals. Miss Monk and her staff are second to none in the medical libraries of Canada in their efforts to make this literature of service to the practitioners of Winnipeg. However, we are much less proud of the accommodation for our growing collection of tomes and the crowded circumstances under which the Library staff must work. When the march of events permits this Society to contribute towards a new Library with more spacious and more dignified reading rooms, may we not fail to throw our weight behind the providing of adequate stacks and working space, and so make this in the complete sense of the term, a modern library.

Respectfully submitted,

J. Wendell Macleod,
Representative to Library Committee,
Faculty of Medicine,
University of Manitoba.

Representative to Welfare Council of Greater Winnipeg

To the President and Members of
The Winnipeg Medical Society:

In presenting this report may I express my appreciation for the honour I have enjoyed this year of representing you on the Health Division of the Council of Social Agencies for Greater Winnipeg. The meetings I have attended have been valuable and stimulating. They have been valuable in information and stimulating in contacts with interesting people.

In this report I shall sketch a few general points which may be already well known to you. I shall also elaborate in some detail on a final point which is new to all of us.

As you are all probably aware, Winnipeg was the pioneer in forming a Canadian community trust. In 1921 the Winnipeg Foundation was organized for permanent administration of funds placed in trust for charitable purposes. At present the principal funds of the foundation total \$3,000.00. In 1950 the sum of \$87,639.64 was distributed among 31 community welfare organizations. There are 80 affiliated agencies, including departments of provincial and city governments as well as private social agencies. A few of these are Red Cross, St. John's Ambulance, Canadian National Institute for the Blind, Children's Aid Society, Mother's Association of Day Nurseries, Victorian Order of Nurses, Kindergarten Settlements, Y.M.C.A., Y.W.C.A., Juvenile Court, Family Bureau, Girl Guides, Boy Scouts, etc. There are 3 divisions of the Council, i, Child Care and Family Welfare; ii, Health; iii, Recreation. Did you know that in the last four years approximately \$385,000.00 has been spent on the purchase of property and subsidizing the construction of club buildings? There are a few special committees such as i, New Canadians; ii, Office Personnel; iii, Housing. In 1950, in Winnipeg, in spite of an increase of 1,438 houses and apartments, the housing shortage continues as the net increase in population was 4,043 for the year.

There is a real advantage in the medical profession's becoming aware of the existing means in the community for handling social and welfare problems in patients. Not only does this apply to indigent patients. Private patients in need of recreation or occupational therapy or broadened interest can be directed to the Central Volunteer Bureau. This is again an organization unique in Winnipeg. Volunteers act as the link between the professional social worker and the general public. In 1950 over 1,215 volunteers accomplished approximately 12,791 hours of work, exclusive of flood activity. This involved 2,500 C.V.B. workers. This bureau fosters such activities as a public speaking course, a course in Citizenship, in collaboration with the University Department of Extension, an Executives' leadership course, senior citizens' recreation clubs, and the newly organized mental hospital recreation plan, SHARE (Selkirk Hospital Auxiliary Recreation and Education).

This then covers a rapid survey of the general scope of the work of the Council for Social Agencies. In 1950 a new function was taken on, in the organization of a Rehabilitation Committee. This promises to be such a highly significant event that with your permission I shall outline the principles of this movement.

On April 14, 1950, the Honourable Mr. Mitchell, Minister of Labour at Ottawa, invited the Canadian Welfare Council to attend a conference on rehabilitation of the disabled. 185 people from all across Canada attended this conference. There were representatives from the Department of Labour, D.V.A., Department of Health and Welfare, Canadian Medical Association, ministerial associations, provincial, municipal and voluntary social agencies. A Rehabilitation Council was constituted to consist of 35 members: 10 from the provinces, 3 from the federal government, 10 from national voluntary organizations and the balance from such interested organizations as universities, labour, employers, etc. In Winnipeg the Council of Social Agencies has formed a Rehabilitation Committee to act with this Council. In February, 1951, a conference of this Council was held in Toronto to work out ways and means. There were 6 delegates from Manitoba to this conference.

The policy as enunciated by the Council, if put into action, may turn out to be as sociologically significant as was legislation to control child labour or minimum wages or the Bill of Rights. Rehabilitation is conceived to be the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable. The programme will include the following services: Medical exami-



1951

1868 The pioneer Claude Adolphe Nativelle isolated the chief active principle of *Digitalis Purpurea*—Digitaline Nativelle.

1927 Sir James Mackenzie and James Orr described Digitaline Nativelle as "an elegant and effective preparation"—*Principles of Diagnosis and Treatment of Heart Affections*, Oxford. Med. Pubs. p. 219.

1945 Harry Gold found it the "preparation of choice for routine use"—*The Choice of a Digitalis Preparation*, Connecticut State Medical Journal, March 1945, Vol. IX, No. 3, p. 193.

Inclusion in N.N.R. from 1942 to the present day led to the Epoch of Digitoxin Therapy, with inclusion in U.S.P. XIII (1947).

igitaline nativelle

The epoch-making product—pure crystalline glycoside from *Digitalis Purpurea*, not an adventitious mixture of glycosides—
is still the yardstick of *Digitalis* Therapy.

1950 Schwartz stated "Digitaline Nativelle will serve better in maintenance therapy"—*A Clinical investigation of the Digitoxins*, *The American Practitioner and Digest of Treatment*, Vol. 1, No. 1, George Macht also states "A striking finding was the greater pharmacological activity of Digitaline Nativelle"—*Special Pharmacology of Digitoxins* Arch. Int. Pharmacodyn., LXXI, No. 3, p. 345.

1951 marks Rougier Frères fiftieth year of devotion to medical advance through ethical specialties of therapeutic excellence.

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ation, including psychiatric; medical treatment and rehabilitation; prosthesis, vocational training and counselling; temporary training and employment in sheltered workshops; payment for maintenance and other costs during training; social case work services; placement in employment.

At the conference recommendations were made as to the means of implementing this programme. It was emphasized that medical examination and assessment of disability are at the core of the whole programme. The principle was stated that medical examination should be a service bought from existing medical services, including private doctors and hospitals. The administration will probably find it necessary to employ one or more doctors for consultation purposes. Medical rehabilitation would involve treatment through existing medical channels and through special facilities such as physiotherapy and occupational therapy.

Physicians will be called upon, at the termination of treatment or in the case of irreversible disability, to define the limits of employment with reference to the effect of sitting, standing, lifting, seeing, hearing, etc., and working conditions such as humidity, temperature, dust, etc. Vocational guidance officers will consult with doctors to analyze these conditions.

The main objective is to secure permanent employment for the disabled person, in a job suited to his highest capacity, at the normal remuneration for that job, in a competitive labour market. This is an objective which we as doctors recognize to be the primary essential element in handling patients with chronic disease. Orthodox medical treatment in such cases represents only the first step in the recovery of such patients. If this plan will provide means for taking the other steps, we know that our medical treatment will be more effective for the patient and less frustrating for us. From this point of view it is important for us to be familiar with the meaning and activity of this new and enlightened organization. I am sure we would all prefer, for example, to see our arthritics or cardiacs or asthmatics working at gainful occupations for a few hours a day, or in sheltered workshops, rather than to be engaged in basketry or bead work or the manufacture of trivial gadgets to sell for a pittance. If this committee can manoeuvre and co-operate with industrial groups to achieve these ends, it is well worth our while to lend our goodwill and co-operation to their work.

All of which is respectfully submitted.

Jessie A. McGeachy,
Representative.

Representative to the Manitoba Medical Review

To the President and Members of
The Winnipeg Medical Society:

I beg to report that this representative was appointed by Council shortly before the February meeting to report meetings of the Society and other pertinent information of the Society to the Manitoba Medical Review.

Three general meetings of the Society have been reported on to the Review.

Respectfully submitted,

J. R. Mitchell,
Representative.

Special Committee, Canadian Arthritis and Rheumatism Society

To the President and Members of
The Winnipeg Medical Society:

This Committee has been in existence only a few weeks but it has had a turbulent childhood. Its first duty was to participate in the campaign for funds which is being conducted by The Canadian Arthritis and Rheumatism Society. On Thursday, May 17, various members of the Committee stationed themselves at the most frequented hospitals and interviewed as many doctors as possible. The response has been very gratifying and the Committee is much encouraged by the fact that

95% of those who were interviewed were sympathetic in their response.

This attitude of the profession will undoubtedly stimulate the interest of the general public in this project. The main campaign of The Canadian Arthritis and Rheumatism Society commences on Monday, May 21, and is being conducted by the members of the Junior Chamber of Commerce. It is felt that the objective of \$58,000 will be met.

Respectfully submitted.

J. D. Adamson,
Chairman.

Section of Anaesthesiology

To the President and Members of
The Winnipeg Medical Society:

The Anaesthesiology Section of the Winnipeg Medical Society has held eight official meetings during the past year. The average attendance has been thirteen out of a membership of nineteen.

This Section comprises the Winnipeg Anaesthetists' Society and the Manitoba Division of the Canadian Anaesthetists' Society.

The new Executive elected for 1951-52 are: Chairman, Dr. Donald Huggins; Secretary-Treasurer, Dr. Douglas Best. Respectfully submitted.

Bernadine Roe,
Secretary-Treasurer.

Eye, Ear, Nose and Throat Section

To the President and Members of
The Winnipeg Medical Society:

Five meetings have been held by the Eye, Ear, Nose and Throat Section of the Society in the past year.

The first meeting was held in November. Dr. L. G. Bell presented a paper on the mode of action of ACTH and Cortisone. This was followed by a presentation of clinical cases by Dr. W. C. Guest on which Cortisone and ACTH were used.

At the second meeting Dr. J. T. A. Sullivan of Toronto was a guest speaker and presented a motion picture on Surgery of the Facial Nerve.

The third meeting was held in February and business of the Section was discussed.

On April 7th we entertained twelve Eye, Ear, Nose and Throat Specialists from Saskatoon, Regina, Medicine Hat, Moose Jaw and Edmonton. The meeting was held at the Royal Alexandra Hotel. During the morning several clinical cases were presented. In the afternoon the following papers were presented:

Dr. W. C. Guest, Winnipeg, Cortisone in Ophthalmology.
Dr. J. D. Anderson, Regina, Conjunctival Tumors.
Dr. E. J. Washington, Winnipeg, Carcinoma of the Middle Ear.
Dr. Walter Alexander, Winnipeg, Some Aspects of Headache.

The final meeting of the Section was held on April 23rd. This meeting was confined to the election of officers for the ensuing year and other business of the Section.

Respectfully submitted,

J. E. Rose,
Secretary

Section of Internal Medicine

To the President and Members of
The Winnipeg Medical Society:

The Section on Internal Medicine has a notification list of sixty members. On October 27th, 1950, a Dinner Meeting of the Section was held in the Medical Arts Club Room. Dr. Wilson of the Department of Hygiene and Preventive Medicine of the University of Toronto, was a guest and spoke briefly.

Dr. F. A. L. Mathewson gave an account of his recent trip to the International Cardiological Congress in Paris.

The executive for 1950-1951 was announced as follows: Honorary President, Dr. C. R. Gilmour.

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Programme Committee, Dr. D. L. Kippen, Dr. J. G. Pincock,
Dr. S. Vaisrub.

Honorary Committee on Medical Economics, Dr. A. Hollenberg, Dr. C. H. A. Walton.

On January 4th, 1951, a meeting was held at the Medical College, where Dr. S. Vaisrub spoke on "Nocturnal Disorders," Dr. E. Gubbay reported on "The Effect of Protein Feeding on Blood Glucose Levels in the Diabetic."

On March 8th, Dr. F. A. L. Mathewson spoke on "The Electrocardiograph in the Apparently Healthy," and Dr. D. L. Kippen on "Gastric Ulcer." A discussion was held on the proposed "Canadian Diabetic Association."

A third meeting is scheduled for May 1st, at which time H. W. Bottomley will speak on "Human Sensitivity to Antibiotics," and Dr. G. B. Leyton on "The Sensitivity of the Organism to Antibiotics."

Respectfully submitted.

Paul T. Green,
Secretary.

Obstetrics and Gynaecology Section

To the President and Members of
The Winnipeg Medical Society:

Four regular meetings were held during the winter season. The first of these was devoted to a discussion of the fees for attendance at obstetric cases. Scientific papers were presented at the remaining meetings. Doctor B. D. Best gave a paper "Ectopic Pregnancy," Doctor A. M. Goodwin addressed the section on the subject of "Delay in Labour," with special

Annual Meeting

Reported by J. R. Mitchell, M.D.

At the annual meeting of the Society Dr. L. T. Kurland of the National Multiple Sclerosis Society was re-introduced to the members on his return to Winnipeg to continue the survey of this city. An initial report of the survey was presented to the Manitoba Medical Association in October, 1950. Dr. Kurland compared the survey in Winnipeg to that done in New Orleans. Locally the incidence was remarkably higher with the ratio of about 1 to 1, with life expectancy about the same.

The survey is now prepared to examine all patients suffering from multiple sclerosis (both private and public) to determine (1) the sign and symptoms manifested, (2) what factors regarding previous infections, diets, etc., are held in common by the patients in Winnipeg and New Orleans, and (3) if possible what ways the patients in Winnipeg and New Orleans differed from their parent population prior to the onset on their illness.

1. None of these patients will be seen without the consent of his physician.

2. Patients will be asked to report to the neurological research clinic, which is to be established, for examination. As many patients are not informed of the diagnosis of multiple sclerosis, such diagnosis will not be related to the patient without their physician's approval.

3. Report on the examination will be rendered to the physician and the patient will be referred

reference to the use of the Kielland forceps. Doctor Ross Mitchell spoke on "Vaginal Delivery following Caesarean Section." All the meetings were marked by free and lively discussion of the topics by all those in attendance.

The new Executive elected for the year 1951-52 is as follows:

Chairman, Dr. A. W. Andison.
Secretary, Dr. C. C. Henneberg.
Counsellor, Dr. A. R. Tanner.

Respectfully submitted.

A. W. Andison,
Secretary.

Radiological Section

To the President and Members of
The Winnipeg Medical Society:

The Radiological Section has held three meetings during the past season, with an average attendance of eleven.

The agenda of the meetings consisted of:

1. Resumes of conventions attended by various members;
2. Discussions on economics related to the specialty;
3. A discussion on incorporation of the Radiological Section of the Manitoba Medical Association;
4. The formation of plans for the mid-winter Radiological Convention to be held in Winnipeg this winter.

The retiring executive were re-elected for the forthcoming year.

Respectfully submitted.

A. W. McCulloch,
Secretary.

back to the physician.

4. Patients will be seen at home by the epidemiologist where possible for environmental and occupational studies.

5. This is a short term intensive investigation and patients will not be followed nor will any treatment be given. Any recommendations on care will be given the physician.

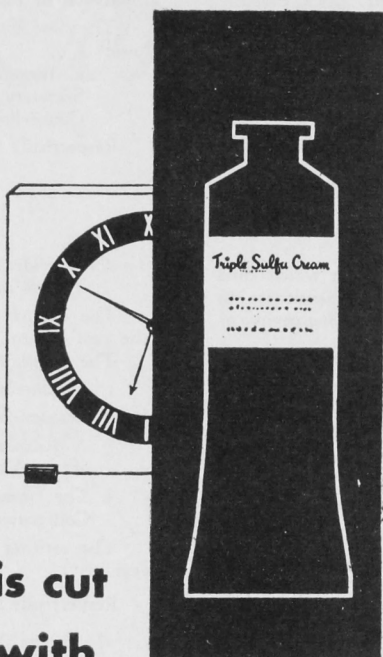
Dr. Kurland's report was enthusiastically received and he was accorded the full co-operation of the society by the members present in the proposed survey. The survey is carried out with the assistance of the Preventive Medical Services of the Provincial Department of Health and Public Welfare.

Abbott Laboratories Ltd. Opens New Winnipeg Branch

In line with its programme of sales and service expansion, Abbott Laboratories Ltd., Montreal, is opening a branch with stock and office facilities in Winnipeg, according to advices received from H. D. Cook, General Manager of the company.

The new branch will be located at 130 Marion Street, St. Boniface, and will enable Abbott to give regional sales and supply service to all the Prairie Provinces. Mr. George Bowen, sales manager for the Prairies will be in charge of the new branch.

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1. Marbach, A. H.: Am. J. Obst. & Gynec. 55: 511, 1948.

Triple Sulfa Cream is available in 3 ounce tubes, with or without the Ortho applicator.



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Department of Health and Public Welfare Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1950		1949		Total	
	April 22 to May 19,'51	March 25 to April 21,'51	April 23 to May 20,'50	March 26 to April 22,'50	Jan. 1 to May 19,'51	Jan. 1 to May 20,'50
erior Poliomyelitis	1	0	2	0	1	5
ckenpox	140	118	70	149	691	729
atheria	0	1	0	1	5	5
rrhoea and Enteritis, under 1 yr.	8	15	5	11	42	59
atheria Carriers	0	0	0	0	1	0
entery—Amoebic	0	0	1	0	0	2
entery—Bacillary	1	0	4	4	8	21
ipelas	0	4	1	8	8	27
ephalitis	1	0	0	0	1	0
uenza	48	198	18	37	738	111
les	591	456	224	284	2263	880
les—German	4	3	14	1	25	16
ingococcal Meningitis	0	3	1	0	10	8
mps	140	175	25	25	830	167
phthalmia Neonatorum	0	0	0	0	1	0
umonia—Lobar	29	39	15	30	141	115
erpal Fever	0	0	0	0	0	3
let Fever	140	83	8	21	498	178
tic Sore Throat	0	3	1	1	9	20
allpox	0	0	0	0	0	0
anus	0	0	2	2	0	1
choma	0	0	0	0	0	1
erculosis	104	67	61	80	314	361
choid Fever	0	1	0	1	1	1
choid Paratyphoid	0	0	0	0	0	0
choid Carriers	0	0	1	0	0	2
ulant Fever	2	1	0	2	5	13
oooping Cough	33	37	6	25	174	89
orrhoea	82	81	55	89	439	412
philis	16	12	24	19	74	102

Four-Week Period, April 22nd to May 19th, 1951

*DEATHS FROM REPORTABLE DISEASES

For the Month of May, 1951

DISEASES	*779,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
White Cases Only)				
proximate population.				
erior Poliomyelitis	1	4	3	
ckenpox	140	90	1976	
rrhoea and Enteritis under 1 yr.	8			
atheria			2	
atheria Carriers				
entery—Amoebic			3	
entery—Bacillary	1		11	1
ephalitis Epidemica	1	1		
ipelas		3	3	
uenza	48		144	5
ndice, Infectious			6	
les	591	75	2607	386
man Measles	4	96	858	
ingitis Meningococcal		1	6	5
mps	140	236	974	
phthalmia Neonatorum				
umonia, Lobar	29			
erpal Fever				
let Fever	140	62	178	72
tic Sore Throat		4	2	13
allpox				
anus				
choma				
erculosis	104	30	77	172
aremia				
choid Fever			5	
ch. Paratyphoid			1	1
choid Carrier				
ulant Fever	2		3	15
oooping Cough	33	11	240	26
orrhoea	82		187	
philis	16		82	

Urban—Cancer, 42; Pneumonia, Lobar (490, 491, 493), 2; Pneumonia (other forms), 2; Syphilis, 1; Tuberculosis, 4; Whooping Cough, 1; Benign Neoplasms, 1; Neoplasms of unsec. nature, 1. Other deaths under 1 year, 13. Other deaths over 1 year, 191. Stillbirths, 14. Total, 218.

Rural—Cancer, 23; Influenza, 2; Late effects of acute infection encephalitis, 1; Measles, 1; Pneumonia, Lobar (490, 491, 493), 3; Pneumonias (other forms), 9; Pneumonia of newborn, 1; Tuberculosis, 9; Diarrhoea and Enteritis, 1; Septicaemia Pyaemia, 1; Benign Neoplasms, 1; Neoplasms of unsec. nature, 1. Other deaths under 1 year, 13. Other deaths over 1 year, 187. Stillbirths, 8. Total, 208.

Indians—Cancer, 1; Influenza, 2; Measles, 1; Pneumonias (other forms), 4; Tuberculosis, 3; Diarrhoea and Enteritis, 1. Other deaths under 1 year, 0. Other deaths over 1 year, 5. Stillbirths, 1. Total, 6.

*As reported to date.

Comment

Measles are still epidemic but are beginning to wane at time of writing. Some communities not attacked before will still feel the brunt of attack.

Scarlet Fever is fairly prevalent and difficult to diagnose because of its comparative mildness. Be on the lookout for it as its complications may be severe.

Syphilis continues to decrease but gonorrhoea is slightly increased over the figure at this time last year. Adequate treatment is necessary to avoid relapse and spread of infection.

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